



PSYCHOLOGICAL THERAPIES REVIEW IN NORTH WALES



Facilitated by *TogetherBetter* Collaborative Consultancy

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Foreword

Andy Roach

**Executive Director for Mental Health
and Learning Disabilities**



In 2017, we embedded a commitment to psychologically-informed care in our all-age strategy, *Together for Mental Health in North Wales*. Today, that commitment remains at the heart of our ambition for modern mental health and learning disabilities care for the people and communities we serve. So I am delighted to receive this review of our existing psychological therapies provision. It is the product of many different conversations with a wide range of stakeholders, and it has generated lots of ideas for the future. It is an important milestone in the implementation of our strategy and vision. It showcases the hard work and creativity of our frontline teams and partners, as well as the vital role we play in national developments in policy, service development, research and teaching. I am proud to celebrate these achievements with you.

Importantly, the report also raises some challenging issues that we must tackle together. Many of these challenges are common to services across Wales and the UK; others are specific to us in North Wales. My team and I are listening to what you have said, we welcome the passion you have expressed, and we ask you to work with us to co-create the improvements we all want to see. At the heart of our response to this review will be an engagement approach which goes beyond what we have attempted before. We want to shape this with you, and will make it our first priority in response to the review.

As I have reflected on the messages in this report, what strikes me most is that psychologically-informed care is a responsibility for each of us. Whether we provide clinical care as part of a multidisciplinary team, have an operational management role across a network of services, or design and deliver strategic developments to impact across the whole system, we each have a part to play in building on our successes and improving outcomes for local people *and* our workforce. If this is something we have not yet fully embraced, then this has to change. My hope is that we can work together to do this, and hold each other to account to live the values that I see in action every day in our services.

Thank you to all of you who have given your time to contribute to this process. I hope it is just the start of a constructive and impactful collaboration, through which we will continue to improve access to high quality, evidence-based therapeutic interventions for everyone.

Executive Summary

Betsi Cadwaladr University Health Board's Mental Health and Learning Disabilities Division commissioned this review in order to:

- clarify the way in which its psychological therapies services currently work
- explore the extent to which psychological mindedness is embedded in the culture and practice of its wider mental health services
- test its readiness to increase access to, as well as quality of, psychological therapies
- outline a roadmap towards improvement, in line with its overarching strategy.

As a team of reviewers, we did this by:

- holding conversations with over fifty stakeholders in one-to-one or small group settings, as well as attending relevant meetings
- reviewing documentation and data about psychological therapies and the wider multidisciplinary services
- seeking out user experiences of care
- undertaking an electronic resource mapping exercise
- facilitating three area-based workshops with frontline staff and service user representatives

We found many examples of positive and innovative practice being pursued at team and specialty levels, as well as opportunities being seized for additional investment from Welsh Government. However, we also found persistent and entrenched structural, systemic and cultural obstacles to fulfilling the ambition for psychologically-informed care across the organisation. For example:

- a lack of shared vision about what you are seeking to achieve through psychologically-informed care and what it means in practice – confusion as to the core offer
- significant unwarranted variation in provision, access, team working practices and culture amongst the multidisciplinary workforce at all levels
- unacceptably long waits in some areas, in part associated with pathway design which is under-resourced and not fit for purpose
- a lack of strategic clarity and oversight at Health Board and Divisional levels; a piecemeal and fragmented approach to pathway development rather than full implementation of stepped care
- a lack of strategic and integrated workforce development
- an enormous data deficit, leaving intelligence-driven decision-making wanting

- a sense of despondency and, in some places, learned helplessness as to how the organisation might work itself into a better place

In short, it is our view that neither the system of care nor the culture is yet equipped to deliver psychologically-informed care as the norm, so change is inevitable. We encountered both enthusiasm and scepticism about this prospect.

The core message we hope you will take from this report is that improving access to psychological therapies, and embedding psychologically-informed approaches, requires **whole system change**. Achieving this goal requires commitment and contribution at strategic and operational levels from clinicians, managers, partners, regulators, and from people who access services. It is as much about mindset as it is about practical solutions. If the potential contribution of psychological approaches can be actualised, the benefits for both service users and staff in North Wales are enormous.

Our Recommendations

1. Focus first on engaging staff.
2. Co-create a vision for psychologically-informed approaches.
3. Design and equip pathways of care that are fit for purpose by:
 - a. addressing the legacy waits in East Adult Mental Health
 - b. making stepped care a reality
 - c. tackling inequality of access
 - d. looking at out of county repatriation potential.
4. Devise a strategic workforce plan to build capacity and capability, and phase its implementation, with clear resource commitments at each stage.
5. Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.
6. Pay attention to the enablers of change:
 - a. take urgent action to tackle the gaping intelligence deficits in services
 - b. strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee
 - c. make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid 'big bangs' and initiative overload.

Introduction

1. Definitions

We want to start with clarifying the use of terminology in this report. Language is important, and it is also a potential source for confusion and misunderstanding.

Psychological therapies have been defined as

‘treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol. They are delivered in a structured way over a number of sessions by a suitably qualified practitioner.’

(Matrics Cymru Guidance for Delivering Evidence-Based Psychological Therapy in Wales, 2017)

Practitioners include Clinical Psychologists, accredited therapists who have a core profession such as mental health nursing or occupational therapy, and accredited counsellors.

Psychologically-minded (or psychologically-informed) services are

‘those in which – at all stages of assessment and intervention – the psychological needs of service users are considered and addressed through the use of evidence-based interventions. Furthermore, a psychologically-minded service focuses upon the quality of relationships between practitioners and service users in the delivery of all treatment and interventions. These relationships provide the foundation for service delivery.’

(Psychological Therapies in Wales Policy Implementation Guidance, 2012)

Low intensity **psychological interventions**, shown to be highly effective when applied in the right circumstances, can be offered by any clinician equipped with some core skills and appropriate supervision. They cover a very wide range of interactions with service users, and underpin an ethos which values and believes in the prospect of living a ‘life beyond illness’ (recovery). When psychological approaches run through every aspect of care, there is a coherence between multidisciplinary clinicians which enables the service user to develop their own skills from the outset, rather than wait to work with a specialist practitioner.

2. The Role of Psychological Therapies in the Wider Mental Health Service

The value of psychological therapies is well-established as a core element of modern mental health care, consistently reflected in policy, strategy and

evidence-based practice (including NICE guidance). In Wales, there is a solid strategic context for and policy commitment to psychological therapies, which includes:

- Psychological Therapies in Wales Policy Implementation Guidance 2012
- Matrics Cymru Guidance for Delivering Evidence-Based Psychological Therapy in Wales 2016 (which covers adults, older adults, and people with a learning disability)
- Together for Mental Health Strategy 2012 (and North Wales' strategy of the same name in 2017)
- Access targets for psychological therapies in Wales, which are becoming increasingly rigorous
- The Mental Health (Wales) Measure 2010, which includes statutory responsibilities to ensure a range of psychological therapies is available within both primary and specialist settings
- Matrics Cymru for Children's Services is expected later this year

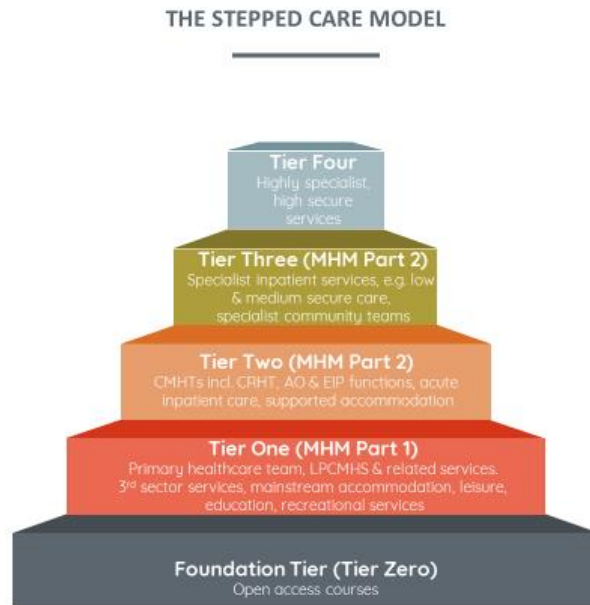
Yet many areas across the UK continue to face challenges in improving access to high quality, evidence-based, condition-specific therapeutic interventions for the diverse communities they serve. According to the *Equality and Human Rights Commission*, the number of people waiting for mental health treatment has doubled in the last six years in Wales, despite increases in funding (*Is Wales Fairer?* 2018). North Wales is one of these areas, and the East area is an outlier across Wales for its waiting times for psychological therapies. In its local strategy, *Together for Mental Health in North Wales*, Betsi Cadwaladr University Health Board (BCUHB) has made a clear commitment to:

- improve the availability of a range of psychological therapies, including online therapeutic interventions
- ensure psychologically informed (community) services are at the heart of what they do, focussing on:
 - making sure psychological intervention/therapy is evidence-based and effective
 - ensuring a timely and multidisciplinary approach
 - making sure the intervention happens as quickly as possible
 - choosing the most appropriate and effective intervention/therapy based on a collaborative and individualised formation of the person's difficulties
 - encouraging all services to be trauma-informed

Delivery of this strategy since 2017 has focussed on prevention and early intervention, and improvements in the acute care pathway, working together with service users, carers and the third sector to build an identity around the 'iCAN' ethos – *independent, contributing, active and networked*. This review is an

important step towards a renewed focus on psychological mindedness across all services, including better access to high quality psychological therapies.

3. The Stepped Care Model



The model of provision for whole system mental health services that is advocated widely in NICE guidance, and adopted by Matrics Cymru, aligned with Mental Health Measure requirements, is called ‘stepped care’. The goal is to match evidence-based interventions with needs in the most resource-effective way, including emphasising the value of self management and wellbeing in communities. According to NICE guideline *Common Mental Health Problems – identification and pathways to care* (2011), local pathways based on stepped care should:

- provide the least intrusive, most effective intervention first
- have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- not use single criteria such as symptom severity to determine movement between steps
- monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed.

While this lends itself to pathways for anxiety and depression, it is less helpful for other needs. Complex co-morbidities mean it is important to remain patient-

oriented when planning individual care and support, so this need for flexibility is important to preserve within the design and delivery of stepped care.

On a related note, it is important to highlight that the Matrics takes a **non-diagnostic approach**. It assumes, rightly, that most people accessing secondary care services are likely to have co-morbid presentations. This requires assessment, formulation, and care planning to be integrated, transdiagnostic and multidisciplinary. In order for those things to be possible, the system across the tiers must be designed, delivered, evaluated and improved accordingly. It is worth bearing this in mind throughout the reading of this report.

4. The Scope of the Review

BCUHB's Mental Health and Learning Disabilities Division commissioned this review in order to bring clarity to the way in which its psychological therapies services currently work, the extent to which psychological mindedness is embedded in the culture and practice of its wider mental health services, to test its readiness to increase access as well as quality, and to outline a roadmap towards improvement, in line with its overarching strategy.

The review was tasked with looking at psychological therapies in:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult Mental Health Services (AMH)
- Older People's Mental Health Services (OPMH)
- Substance Misuse Services (SMS)
- Forensic and Rehabilitation Services
- Learning Disabilities Services (LD)
- across primary and secondary care, including third sector provision

with specific reference to the Matrics Cymru Gap Analysis, and the Together for Mental Health in North Wales strategy (but noting that Matrics does not cover CAMHS, and the strategy does not cover SMS or LD).

The review was not tasked with looking at:

- Liaison and health psychology
- Eating disorders
- Perinatal mental health

At the mid point of the review, and based on interim findings, an agreement was reached with the sponsor to focus the remaining review period on the services where the need appeared greatest – namely AMH. This means that the review was more detailed in AMH than in the other specialities. However, we are confident that the findings we have reported across each specialty are reliable. The review has been an ideal opportunity to showcase good practice and

recognise the hard work and dedication of so many people working in the field. It has also faced a number of constraints and challenges:

- A fundamental lack of routine accessible information, and/or data quality concerns – clinical, demand and capacity, staffing, training, finance, population needs. This has prevented completion of the Matrics Gap Analysis in full.
- Capacity for potential contributors to participate, as a result of competing priorities (time), and some scepticism as to the motivations for an independent review and its perceived impact (inclination).
- Scale and breadth of diversity of the services in scope – from primary care CAMHS to medium secure care to memory assessment; NHS and third sector; urban and rural; multi-professional; acute and community
- A risk that AMH will overshadow other services which face equally pressing problems from the perspective of their client group.

5. A Systemic Understanding

Many of the challenges that manifest themselves in BCUHB's psychological therapies (e.g. waiting times; demand and capacity pressures; lack of role clarity) are a function of the wider system within which they operate. Every person accessing services will have some degree of psychological need, but that doesn't mean that every person needs to see a Clinical Psychologist or Psychological Therapist. The extent to which this basic principle is embedded – the capacity and capability within the wider system to respond to these needs in the right place and at the right time – is fundamental to the achievements of any specialist service. This means it is essential to look at this wider system, in order to gain a deep understanding of what is happening and what might work better in future.

This is equally true in seeking to make sense of the 'softer' aspects of organisational working, such as understanding interprofessional relationships and behaviours. This systemic perspective is the one we have taken throughout this process, and we invite readers to do the same. It is our view that any attempt to ringfence the specialist psychological therapies for scrutiny in isolation of the wider system is flawed, and will dramatically reduce the prospects of finding solutions that will work.

What We Did

1. Ethos

As a team of reviewers, we set out to do three things through this process:

- Respect the local context, and nurture the passion and expertise of local people to address the challenges they face together;
- Take a strengths-based approach, looking for opportunities to celebrate and build upon positive practice in BCUHB;
- Be honest about what we found, and facilitate constructive and collaborative dialogue towards systemic improvement.

We leave others to judge whether we were successful.

2. Methodology & Constraints



We used a variety of methods, both qualitative and quantitative, to gather intelligence to inform the review and its recommendations. The blend of methods evolved between initial design and mobilisation, when it became clear that there is very limited relevant information that is routinely and systematically collated and considered about psychological therapies across BCUHB. So it was necessary to generate much more primary research than was originally envisaged. Some readers may feel this means the review evidence is overly

subjective. We attempted to address this in two ways. Wherever possible, we sought to triangulate subjective narrative account with objective information in order to reach conclusions. We also ensured we spoke with a broad range of stakeholders to get a balance of views. However, the paucity of data has restricted our scope to triangulate as thoroughly as we would have wished. It has also prevented completion of the Matrics Gap Analysis to the level of granularity indicated. Where subjectivity is a particular challenge, we have endeavoured to highlight this within the report. The difficulties we encountered as reviewers are, of course, mirrored for those responsible for running the services.

The methods were:

- *Desktop research* – we reviewed a range of documents provided by BCUHB, covering strategy, funding, service models, operational resources, policies and procedures, service evaluations and audit, performance data, development proposals, and contractual information. We comment later on the adequacy of some of this information for its intended purposes. We also looked at national policy and strategy in relation to psychological therapies. Finally, we undertook a high level review of the literature around interdisciplinary and team-based working.
- *Field research* – we held over fifty conversations, in person or by ‘phone, with individuals or small groups, all of whom have an interest in improving access to psychological therapies. We also attended meetings with third sector partners to discuss their views and ideas. We travelled to a broad range of clinical sites across the region. The number of interviewees by speciality varied according to the degree of focus agreed with the sponsor.
- *User voice* – we asked Caniad to facilitate a feedback exercise amongst local communities. We received helpful input from Bangor University’s People’s Panel, enabled by the Service User Representative on the Psychological Therapies Management Committee. We read case studies from third sector providers, reviewed a Learning Disabilities client satisfaction audit, and we looked at summary data about compliments and complaints to BCUHB.
- *Resource mapping* – we undertook a digital exercise to capture key information at a team level about psychological therapies staffing, range of therapies, training, and barriers to progress (in the absence of reliable data available centrally). We received thirty six responses.
- *Area-based workshops* – we facilitated three workshops across West, Central and East areas, to which around fifty five frontline (mainly psychological therapies) staff from BCUHB and the third sector came, along with service user representatives from Caniad and the BCUHB Psychological Therapies Management Committee. The workshops focussed on mapping existing processes for the delivery of care, and using

this information to generate change ideas, which we have synthesised within this report's recommendations.

In terms of governance, the review was overseen by its sponsor, the Director of Partnerships for Mental Health and Learning Disabilities, to whom a monthly progress report was provided. It reported into the Strategy and Service Redesign Group, and the Together for Mental Health Partnership Board.

We recognise that we could have continued the review process for many more months, examining individual pathways or services in greater depth, and broadening our conversations even more. Some services have received greater focus than others, according to the scale of need and urgency of attention. It is a constraint of which we are very mindful. *We encourage those who can add greater richness to this narrative to do so*, as the organisation determines the next steps it will take towards improving the psychological mindedness of its services, and access to high quality psychological therapies.

What We Found

1. Overview & Links

This chapter is structured by specialty, and is framed around the key components of the Policy Implementation Guide and Matrics Cymru. Our findings are based on the intelligence generated or collated through the methodology we used (as described in Chapter 2). What you read in this chapter is what you told us and showed us. Sometimes there are differences of view between contributors. We have endeavoured to represent those differences fairly.

At the outset, we recognise that the Matrics doesn't cover Children's Services. We also acknowledge the views expressed by many that it is heavily focused on services for adults of working age. However, in seeking a consistent means of structuring our feedback, we have taken the view that there is sufficient commonality of issues to warrant a single format.

We wish to highlight that many of our findings are consistent with those referenced in the Together for Mental Health North Wales strategy in 2017, and the more recent HIW/CIW Joint Thematic Review of Community Mental Health Teams (2019). We strongly urge the organisation to consider its response to this review in this context, and, in planning action, make the connections that are clearly evident across the whole system.

We recognise that some of the messages in this report are challenging, and want to highlight some important points to bear in mind:

- The challenges for psychological therapies services in North Wales are mirrored throughout the country and across the UK. Mental health needs and expectations of psychological treatments continue to grow, but service and financial pressures hinder innovation and strategic development. North Wales is not alone in grappling with these issues.
- The desire to standardise approaches through stepped care is not without its limitations. The scale of complexity that all mental health services are facing presents clinical and service challenges that cannot always be answered by recourse to an evidence base or standardisation. There is much untapped opportunity, but there is no magic answer.
- The Divisional leadership team made a commitment to commission this review because a psychologically-minded offer is at the heart of its strategy. The team recognises the need and importance of prioritising this area of provision for improvement. This commitment was consistently and genuinely expressed to us.

- To our knowledge, BCUHB is the only Health Board in Wales to have invited independent scrutiny of its psychological therapies services. This signals courage and commitment to open learning and improvement that should be properly acknowledged by all.

2. Overarching Factors

The Matrix highlights several overarching factors which impact on psychological therapies, in recognition of the broader organisational context within which individual specialties work. We look at those here, and have added some related points.

In line with Welsh Government expectations, there is a BCUHB-wide **Psychological Therapies Management Committee** (PTMC) in place, chaired by the Interim Head of Psychological Therapies. It has a strategic remit for services beyond the scope of this review, and scrutiny of its functioning has not been within our brief. However, it has arisen in various conversations. There seems to be broad agreement that its authority, role and relationship to the Divisions and their priorities are unclear – in other words, *who does what and when?* Board level PTMC membership and sponsorship are similarly unclear. An organisational strategy for evidence-based psychological therapies is not in place, although individual specialty strategies make reference to them. We have not seen evidence of organisation-wide strategic workforce and improvement planning in relation to need – for example, a consistent approach to managing capacity and addressing waits, or a plan that builds capacity and capability across the entire clinical workforce.

The Chair describes a strong relationship with the national PTMC, close working on national developments, and there is some cross membership of both committees.

At a Mental Health and Learning Disabilities Divisional level, the **governance** of psychological therapies does not appear to be wholly integrated. On paper, there is a Divisional infrastructure which is organised around area and specialty Quality, Safety and Experience groups (QSEEL), into which psychological therapies feed. Examples of a small number of individual project evaluations were shared with us (e.g. DBT-informed coping skills group), as was a referrals audit from one Community Mental Health Team. However, we didn't hear or see compelling evidence that the needs, risks, priorities and potential value of psychological therapies were fully considered in these arrangements, particularly at Divisional level. There is a Medical and Psychology Workforce Group, but there appear to be differences of view between members as to the purpose, focus and value of this group. Psychology representation has not been present for some time. This appears to be an area in which the separation of the management of psychological therapies from the wider services is an obstacle.

In Children's Health, we observed a more embedded Divisional approach to the leadership and delivery of psychological therapies within the core services, at strategic and operational levels, which is then reflected in its governance arrangements. However, the questions about the relationship between the Division and the PTMC are equally relevant for Children's Health as they are (adult) Mental Health and Learning Disabilities.

Equal access is another overarching factor. Systematic data on population need, access and availability of psychological therapies are not collected and triangulated, so it is difficult to be specific as to where priority should be targeted. We were able to identify some of the issues via the resource mapping exercise, as well as interviews and service user feedback. The anecdotal evidence suggests that:

- When the overriding service challenge and priority is to improve access by cutting waiting times, access *to what* and *by whom* become secondary considerations. Can I access help through the medium of Welsh? Can I access help within a reasonable travel distance? Can my specific communication needs be met? Have reasonable adjustments been made? Is the therapy most suited to my needs available locally? Can I move easily between services according to my needs? Does the offer maximise my chances of building a therapeutic alliance with my therapist? In short, is the offer patient-centred? Responding effectively to these questions adds further challenge to already-overwhelmed services.
- For some, this means that the offer is entirely inaccessible to them – e.g. for people with a learning disability or a substance misuse need trying to access core services (e.g. AMH). Those people are then reliant upon some compensatory response in the wider system – e.g. by LD or SMS services developing their own resources to respond to need. Or for people who may fall into a group considered to be 'hard to reach' for whom health inequalities are most damaging.
- For others, it may mean accessing help that is sub-optimal for their needs or out of line with national guidance – e.g. for people whose first language is not English, or for people who would benefit from DBT but can only access CBT.
- Unmet need is an inevitable consequence, and this generates more demand upon services over time. It is safe to conclude that this disproportionately affects people who are already marginalised. There is a process for capturing unmet need at team level, but interviewees were honest in saying that this is often not prioritised as meaningful responses do not transpire. It might also be interpreted as indicative of the sense of learned helplessness that prevails.

3. Children's Services

'Patients before profession'

1. In Brief

Based on the intelligence we gathered for Children's Services, we saw consistent evidence of a whole system approach to the planning, development, delivery and evaluation of psychological therapies. Multidisciplinary integrated working is well-established. This has a positive impact on the Division's capacity to work in psychologically-minded ways across its mental health workforce. Leadership of the partnership, strategic and operational agendas is clear and well-established, and there has been consistent success in securing investment for developments in line with an overall plan for psychological therapies. Processes for evaluating quality and outcomes are in place. When asked what had made this progress possible, one clinical leader said it was a case of 'patients before profession'.

There are challenges relating to growing access times, and recruitment and retention, which are being addressed innovatively. However, the anticipated increases in future demand for CAMHS across the UK, and the significance of early access to lifelong health and wellbeing, require a long view in terms of strategic workforce requirements for psychological therapies. There is opportunity to further strengthen the use of psychological skills within the workforce, as well as improve the interface with AMH.

Note that the tiers within CAMHS are labelled differently to the Matrics for adults. The Matrics for CAMHS is expected later this year.

2. Psychological Therapies Model

Child and Adolescent Mental Health Services (CAMHS) are managed within the Children's Health Division, and deliver Tiers 3 and 4 of services. There is an area-based structure, aligned to Local Authority boundaries, and underpinned by a Regional Advisory Group for Psychological Therapies. This helps to ensure a consistent approach to service delivery and development, still flexible to local needs.

The Psychological Therapies workforce is fully integrated into the multidisciplinary team, its management and budget, and works to a single operational policy. Clinical lead roles are often undertaken by Clinical Psychologists, including at Tier 4 (acute).

Non-specialist universal support at Tiers 1 and 2 is provided across the third sector, as well as BCUHB's primary care mental health service for children and young people. The latter has recently been reviewed by the Delivery Unit.

The integration of services across primary and secondary care enables management of demand and capacity across the whole system, using the well-established Choice and Partnership Approach (CAPA). Waiting times have grown for both assessment and intervention since 2017/18, with target compliance for the latter being significantly lower than the former. Waits for neurodevelopmental assessment are much longer (over a year in East). Clinicians flagged a concern that patients are allocated to clinicians at the Choice appointment according to who is available, which may or may not coincide with who is most appropriate to address their needs.

There is a set of Regional Priorities for 2018-21 in place, although an overarching Children's Plan is still developing. CAMHS is included within the *Together for Mental Health North Wales* strategy. There is a desire to see a stronger strategic influence and impact from the Psychological Therapies Management Committee.

3. Psychological Therapies

Evidence from the resource mapping exercise indicated a good range of therapy options, reasonably balanced across teams but still with some local variation. There is good evidence of the use of psychological interventions by all clinicians, which enables specialists to focus on the more complex work, as well as providing support to the wider team. However, there are some gaps around EMDR, IPT, family therapy and low intensity interventions (sometimes related to lack of access to supervision). According to resource mapping data, typical treatment length for most patients is seven to twelve sessions in the community.

There is a commitment to improve access for marginalised groups, such as children with a learning disability.

4. Psychological Therapists

The even balance of the psychological therapies skill mix across bands is a noticeable feature of the workforce in comparison with other specialties, from consultant grade to newly qualified, as well as the numbers (33.9wte in post), suggesting that there is a critical mass in the establishment to sustain services. Vacancies as at 31 May 2019 ran around 14% (5.3wte), with recruitment and retention challenges described as being longstanding. New roles at Band 8A are being introduced, allowing postholders opportunities to consolidate their learning and development at that level in their first year in post.

Job planning is undertaken in collaboration with team leads, which helps to ensure that capacity is fully integrated into the wider multidisciplinary team (MDT) – this is a relatively new development.

5. Training

There is a wide range of training opportunities in evidence-based therapies, aligned to strategic workforce needs across the Division, including IPT, DBT (rolling programme) and family therapy. A trainer post has been established with Bangor University to train CAMHS staff initially in CBT. This capacity is growing, in collaboration with AMH. CAMHS would welcome more shared training opportunities with the Mental Health and Learning Disabilities Division.

Mentalisation-based therapy requires development, and there is an enthusiasm for it in Tier 4 services.

Some clinicians are trained in the use of dyadic developmental psychology for attachment disorder, but do not practise due to a lack of clarity about its use in North Wales. This would entail cross-agency working, and include children and young people in the care system.

6. Supervision

Supervision is appropriately maintained for therapies in use, but some IPT expertise is not put to use as supervision is not available. The position is different in different areas. This is being addressed through training. Investment has been sought to ensure better availability of senior psychologist time to facilitate supervision of specialist clinicians, as well as ensure access for the wider MDT to psychological expertise and case formulation.

7. Audit and Data Collection

Relevant outcome measures are in use across the board (e.g. C-GAS, GBOS, ESQ), and other measures (e.g. MFQ) are used in some teams. These are recorded at an individual level only.

Performance data using metrics such as waiting times and Mental Health Measure compliance is analysed and reported routinely by area.

The team is currently working on establishing clear and measurable quality standards for psychological therapies, to be supported by a workable data management process.

Overall, there is a sense of strategic and well co-ordinated delivery and development of fully integrated psychological therapies in CAMHS. Challenges are well understood and proactively addressed, using collaborative approaches. Tactical use of opportunities for investment are being made, aligned to a clear set of priorities. Nevertheless, there are growing difficulties around timely access linked to increases in demand and pressures caused by vacancies. The publication of the Children's Matrics later in the year will be key to informing future developments.

Key Questions Specific to CAMHS

- Are the plans in place sufficient to address the growing demand upon services and ensure access is maintained and improved?
- How will CAMHS and AMH work together strategically? What is needed for that to happen?
- What opportunities can be created to improve shared learning between specialties, including showcasing what integrated working can look like in multidisciplinary settings?
- What, if any, aspects of Children's Health psychological therapies services have not been considered to the extent that the leadership team would wish, and how might that be addressed?

4. Adult Mental Health Services

'We need to make the most of what we have.'

1. In Brief

Providing a single narrative to describe Adult Mental Health services is challenging, as the variation between areas and teams, in terms of population, history, identity, experiences, service configuration and availability, culture, ways of working, and more, is significant. So this chapter attempts to draw out common factors that emerged through the review, but every factor may not resonate with every team.

More detailed findings about the nature and extent of interdisciplinary working are covered in Chapter Four.

We found many examples of targeted work to address waiting times and access to psychological therapies by psychological therapies staff across the tiers of stepped care. For example, through the development of new posts, redesigned processes, service innovation, as well as efforts to change team practice and thinking. However, this appears to be happening without the benefit of a North Wales system-wide approach or engagement in psychologically-minded care. Both horizontally and vertically, there are untapped opportunities to work smarter across boundaries. The system as it is currently designed and resourced, and the culture that underpins it, are not equipped to deliver the ambition for psychologically-minded care as envisaged in local and national strategies.

It is important to bear in mind that not all therapy works. It is not for everyone. We noticed a sense and expectation across the service as a whole of 'needing to offer something', rather than providing an outcome-oriented approach for people who are most likely to benefit. Helping both clinical colleagues and service users to understand both the potential and limitations of therapy in different circumstances is key.

2. Primary Care – Tiers 0 and 1

Much of the Division's strategic work in the last two years has focussed on increasing access to opportunities outside specialist mental health services, working closely with partners (e.g. education; community groups). While these are not specifically related to psychological therapies, they are about building awareness, community resilience and psychological skills to cope during difficult life circumstances. These developments have the potential to improve universal access at Tier 0.

The first opportunity to offer a psychologically-informed service response is at the first point of contact, usually in primary care. Yet experience is often very different. The Joint Thematic Review of CMHTs (2019) identified the importance

of making marked improvements in assessment at primary care level, so that there is a consistent and capacity-oriented approach to step up into specialist multidisciplinary services in secondary care. This requires access to specialist psychological therapies expertise within the primary care MDT, so that decisions about care planning are properly informed. This is not the norm in the services we reviewed. Without this, long waits accumulate for access to a specialist opinion, which may ultimately determine that psychological intervention is not indicated.

Services for psychological therapies at Tier 1 level are comprised of two core elements across the region.

i. **Parabl**

Parabl is a partnership **model** of third sector providers, co-ordinated by CAIS and delivered, with CAIS, by local branches of MIND as well as two other small charities. The pathway provides low level psychological interventions. It is based around initial telephone assessment, undertaken on the day of referral by the CAIS team, using PHQ9 and CORE10 instruments to assess suitability. Most people self refer. If suitable, the intervention options are cCBT, group work or one-to-one counselling, all of which are short term (usually less than six sessions). The pathway does not include direct access to Tier 2 services, so referrals, including crisis, go back via the GP. This negates the notion of step up and step down access. Drop out rates between each step of the pathway (referral to assessment to treatment to planned outcome) run at around 50%.

Call assessors are counselling-trained **therapists** (1.33wte). There are 2.4wte accredited counsellors and 0.8wte qualified counsellor. They are supported by 2.5wte administrators and 1wte Service Manager, who provides clinical and management **supervision**. There is a small amount of volunteer and student input. There is no interaction with Tier 2 colleagues, for example for consultation, supervision or capacity management across the tiers. This staffing includes coverage for the Substance Misuse counselling provision.

Therapies offered include CBT, cCBT, psychodynamic psychotherapy, MBCT, self help, bereavement counselling and supportive counselling.

Service **data** for Parabl is the most extensive available across the reviewed services. It is collected and submitted as part of the contract monitoring process on a quarterly basis. Data includes demographic information by area, number and type of assessments and interventions, waits, DNAs, outcomes (including the IAPT Recovery Rate metric), and service user feedback. In Quarter 3 of 2018/19, over 90% of people rated their experience as 'beneficial' or 'very beneficial'.

Waiting times for assessment reach the target on average 99% of the time, and at that stage people receive relevant self help material and signposting to other

community resources. However, the wait for treatment (i.e. to start counselling or access a Parabl group) is just 26% (Q3 2018/19 data). This is as a result of capacity/funding shortfalls for groups, which vary between areas. Parabl activity is not reported under Part 1 of the Measure.

The funding of the contract by BCUHB (c.£300k per annum) has remained unchanged since inception six years ago, despite significant ‘overheating’ of contractual activity levels. CAIS reported that it subsidises a financial loss on the contract every year.

The Parabl model is described by its partners as working well for a number of reasons:

- While CAIS holds the contract with BCUHB, there is no single dominant partner in the working relationship
- Each partner knows their community very well
- There is a central point of access, and the pathway within Parabl works smoothly
- Each partner brings added value through the other services they provide and can signpost into (e.g. peer support)
- The service is community-based and accessible (not seen as part of the NHS)
- There is a menu of options for support
- The service is self-directed, not prescribed
- It delivers good outcomes for people, often beyond the service itself (e.g. by opening up other community-based opportunities that the provider offers)
- The partnership is clearly governed, and partners meet regularly

The richness of community connection was particularly striking within Parabl. Knowledge about what exists in the wider community to support people in their health and wellbeing, and how it can be accessed, were notably stronger in our discussions with third sector partners than it was with the NHS. Building wellbeing capacity across the system requires knowledge of what is out there, something that the NHS is not traditionally skilled at or has valued. There is considerable potential for specialist services to learn from and collaborate closely with the third sector to build this capacity.

Limitations of the Parabl service are evident in the design of the wider system, in that the enablers of stepped care are not evident. We heard accounts that there is a gap between the upper end of what GPs are able to ‘hold’ in general practice and the lower end of what Parabl will accept, which has precipitated the establishment of the Active Monitoring service in some areas (see later). We heard an equivalent gap between thresholds from Parabl into secondary care

services. The impact of the service on wider demand in the system has not been analysed.

ii. Local Primary Mental Health Teams (LPMHTs)

The LPMHTs are accessed via the Single Point of Access (SPOA) for BCUHB's specialist mental health services, with which they are co-located. They are oriented around meeting Part 1 of the Mental Health Measure, which requires assessment within 28 days of a routine referral, and 48 hours for urgent referrals. We were told consistently that primary care practitioners' capacity is absorbed by this assessment requirement (which includes administrative tasks as well as direct patient contact), and time isn't protected to deliver low intensity interventions as intended. In many conversations, we heard the LPMHT function described as 'assess and signpost', because it has insufficient time to offer meaningful intervention. The Mental Health Measure monthly statistics for quarter one of 2019/20 show that:

- There are around 1200 referrals received each month
- Around 65% are assessed within 28 days
- Around 950 people (c80%) are discharged from services every month. This stands out for further exploration and potential for better pathway management 'upstream'.
- Around 80 people are referred into secondary care
- Of those who do receive a therapeutic intervention (c150 per month), around 70% will start that intervention within 28 days
- The number of people waiting for intervention that has not yet started are not included within the Welsh Government data set. This is an important but unknown piece of the jigsaw

Caseloads were described by some clinicians as unmanageable, with numbers of over 100 cases per clinician mentioned by one respondent to the resource mapping. Reasons given for high caseloads include:

- Gaps in thresholds between services (Parabl to LPMHT to CMHT)
- An expectation that all referrals are accepted for assessment by LPMHT
- An inability to make timely referrals into CMHTs due to bottlenecks
- An inability to refer directly to specialist psychological therapies services (referrals have to come via the CMHT)

These could be summarised as 'failure demand' generated as a result of system design and capacity as well as silo working, rather than clinical need *per se*, the consequence of which is that people are unable to access the right care at the right time.

From the two resource mapping responses, we were told that the LPMHTs are staffed by Band 6 RMNs who are trained to provide assessment of needs, but

who may not be trained in low level psychological interventions. Some have a Support, Time and Recovery worker. Clinical supervision arrangements were unclear.

iii. Other Primary Care Psychological Therapies Services

In addition to the North Wales-wide provision, some areas have services at Tier 0 or 1 either as a legacy or as a new initiative in response to a pathway deficit.

The **Primary Care Counsellors** team in the West area has been established since 2002, and has previously covered every GP practice, receiving direct GP referrals for brief interventions. Now, it operates on a much smaller scale with a handful of long-serving staff who are attached to the LPMHTs, with referrals coming through SPOA. Their role and fit within the set of services that has subsequently been created do not appear to have been considered strategically.

MIND Active Monitoring is a 12-month pilot service, based on national MIND's model, which started in Denbighshire and is now operating across several areas. It is commissioned and funded through GP Cluster funds. Through an eight week course of one-to-one sessions based in GP practices, it provides self-directed psychoeducational support using CBT approaches. The intention here is to plug a gap in support for people who do not meet the criteria and/or have to wait a long time for other services, and who present regularly to their GP seeking help. It is reported to be popular amongst GPs. As a new service, the data available is not yet fully analysed.

Healthy Prestatyn is a great example of a biopsychosocial model in action. While not exclusively aimed at people with mental health problems, it works alongside GPs to help people with chronic conditions to self manage, using a strengths-based approach with individuals and communities. A team of four Occupational Therapists, with backgrounds in mental health and palliative care, work largely with psychosocial issues, and are able to respond in crisis situations for people with greater levels of need than can be addressed in other parts of the primary care system. They help people to build the skills to use community resources, such as managing anxiety and building self confidence. They encourage people to make their own management plans, looking at the person's whole context (work, home, social) to do so. They provide one-to-one work up to six sessions, and facilitate a five session course based around the Five Ways To Wellbeing. Other courses include a CBT group for chronic back pain, and a bereavement group. They are building links with the ICAN centres. Audit data shows a positive impact upon GP attendance levels (75% reduction), while anecdotal data for impact upon secondary care is also positive. As one of the OTs reflected, 'it is vital to support self management skills from day one. Otherwise you build expectations of miracle solutions, and thus deskill and disempower people, which leads to increased use of services.' The early intervention approach, which builds on strengths, is key to its success.

3. Secondary Care – Tiers 2 and 3

3.1 Psychological Therapies Model

Community Mental Health Teams provide all non-acute community-based functions in AMH, including psychological therapies. While the organising principles for these services are not explicitly spelt out, the core offer seems to be organised around compliance with the Mental Health Measure. The unintended consequence is that quality in evidence-based care planning and delivery is at risk of being overshadowed, in pursuit of initial access and maintenance. This is consistent with the findings of the all Wales Joint Thematic Review of CMHTs (2019). Strategy and service redesign work is currently oriented around attachment theory, strongly advocated by the Medical Director, but this is in its early days and not yet evident in day-to-day working.

Psychological therapies staff are variously aligned – some clinicians describing themselves as fully integrated with the MDT, others describing an MDT resistance for that to happen, and other professionals suggesting that there is a deliberate intent for Psychological Therapists to work in detached ways. Line management arrangements are separate. Referral arrangements vary, but most, if not all, appear to require CMHT referral ‘into’ psychological therapies. While the intention behind this is about responsible use of a very scarce resource, it sets up the conditions for waiting lists (and therefore risks) to build, as there is no shared ownership or responsibility for the total capacity of the system. There is no direct access from primary care to secondary care psychological therapies, so referrals must come via SPOA, meet the (non-standardised) criteria for secondary care, and then be allocated for care co-ordination, regardless of the need for multidisciplinary input. This is often handled by holding service users on the caseload of a Consultant Psychiatrist, pending psychological assessment and possible intervention. Roles and responsibilities between multidisciplinary team members are left for individual teams to work out, and thus inevitably vary.

In **acute care**, the model for psychological therapies operates across all wards (i.e. cross specialty) at each inpatient unit. Specialist staffing capacity is designed on the assumption that psychological working is practised across the ward team – i.e. a stepped care approach. In reality, competing demands and lack of protected time mean that nursing staff have limited opportunity to engage in the delivery of psychological interventions, or to develop their skills through training and supervision. Twelve hour shift patterns were mentioned as an exacerbating factor. However, Clinical Psychologists do work closely with nursing staff to support their understanding of a biopsychosocial approach. They make use of existing mechanisms such as ward rounds, clinical meetings and informal discussion to offer this guidance and support. Team formulation meetings tend to occur on an ad hoc basis. Clinical Psychologists also provide an important role in

supporting inpatient staff to explore the psychological impact of the work they do upon themselves, although this tends to be ad hoc rather than formalised, again due to time constraints. They support community staff around the point of discharge (e.g. positive ways to manage attachment issues and continuity) but they do not follow service users into home treatment. This impacts on the sustainability of work that could otherwise be started during admission.

More fundamentally, there may be a case to rethink acute models of care so that they are designed around evidence-based responses to crisis, rather than admission *per se*. Current acute provision for people with a diagnosis of personality disorder is not consistent with the guidelines for psychologically-informed and structured support.

3.2 Psychological Therapies

In **Community Mental Health Teams**, the therapies available are predominately CBT-based. DBT skills have developed widely, but the resource mapping feedback showed that the majority of teams have been unable to make full use of DBT skills amongst team members due to a lack of critical mass to run programmes, and/or a lack of supervision access. It is not clear why neighbouring teams have not come together to create that critical mass (despite some attempts to make this happen), but this is clearly an untapped opportunity for a more co-ordinated pathway for personality disorder.

Another barrier to using psychological skills is that teams report spending their time firefighting demand, managing caseloads and Measure compliance, and so don't have an opportunity to use or develop therapeutic skills. This is unlikely to change within the current service design.

Specific therapies include CBT, EMDR, web-based psychoeducation, DBT, psychodynamic psychotherapy, narrative therapy, TF-CBT, progressive relaxation, relapse prevention, group CBT, ERP, and applied relaxation (although clearly not every therapy in every team, and the variation appears random).

Typical treatment lengths seem to vary, with no standardisation or guide as to what is expected, but most reported over fifteen sessions as typical. Interventions are delivered on group and individual bases. We did not find a standard approach to managing referrals, capacity or waits across CMHTs.

For people experiencing psychosis, psychological therapies provision is patchy. For first episode psychosis, there is a proactive but small early intervention team, with different access arrangements across the three areas. It engages fully with the National Clinical Audit for Psychosis (NCAP) and has also been peer reviewed via the Royal College of Psychiatrists in 2018/19, both of which contain detailed information about current provision, strengths and challenges. The team has been successful in securing new investment, but we were told that this will not be

sufficient to address the needs of the ‘at risk mental state’ population. As this group does not meet eligibility thresholds for other service such as CAMHS and CMHTs, nor readily self-presents in a timely way, this leaves significant unmet need in the community. The gap in provision means the system is generating its own future demand, as the opportunity for early intervention passes and more entrenched health and care needs materialise over time as needs go untreated.

For those with enduring psychotic illness such as schizophrenia, NICE-recommended therapies are CBTp and family intervention. Benchmarking from the NCAP shows that in BCUHB 29% are offered CBTp and 13% are offered family intervention (sample size n=95). This is around the UK average. In the resource mapping responses, eight AMH community mental health teams responded. One team reported offering CBTp, and another reported family intervention. The remaining six offered neither, meaning that NICE-recommended therapies are unavailable to the majority of communities across North Wales. The EIP team is able to provide training in both of these areas, but dedicated psychosocial interventions posts are not a core part of the workforce. We were shown a BCUHB action plan in response to the NCAP audit which included actions in relation to expanding capacity for psychological therapies, but we understand there has not been material progress and so the situation remains unchanged.

Access to psychological therapies was, without any question, the single biggest issue raised by everyone we spoke to, including, of course, people who use services. Waiting times for assessment range from one month (in Rhyl) to over a year (in Wrexham). Welsh Government is in the process of embedding a 26 week target for high intensity psychological therapies treatment. National data indicates that every Health Board is breaching this new target, and there are many complications in capturing data across Wales for valid comparison. BCUHB’s AMH position varies very widely between the six counties, so a regional average is not meaningful. A snapshot of 26 week breaches at 31 May 2019:

Ynys Mon	17
Gwynedd	20
Conwy	51
Denbighshire	14
Flintshire	45
Wrexham	249 (the highest in Wales by a significant margin)

These figures represent a marked improvement in Central, and a steady picture in West. The East area has a particular legacy problem with very long waits, which are generally attributed to a previous model of service more than population need. One clinician described having just cleared the waiting list from 2014, and had found that a large number of people were not suitable for

treatment. While the East position is a major outlier, we were reassured that current practice has reduced the volume of referrals to specialist psychological therapies, thanks to significant work undertaken with team colleagues to change practice as well as some increase in staffing.

Tackling Waiting Times in Hafod CMHT

Two years ago, a new Clinical Psychologist took up post in Rhyl, and inherited a long waiting list, in which psychological input was being used as an 'end of the road' option when other interventions had failed. Working alongside the CBT Therapist in the team, she has reduced the waiting time for assessment and treatment to just one month.

She highlighted the following as key to the achievement:

- Provide information to the MDT about what clinical psychology is and what it can do. It's not a magic answer and won't be suitable for all
- Engage the referrer in making a purposeful referral – discuss it with the service user, find out what they are seeking from it, establish some motivational tasks with the service user to test out willingness to engage
- Support the referrer in making a purposeful referral – be available for consultation, be 'on hand' to the team
- Offer a two hour assessment appointment to establish if psychological intervention can help and if the person is motivated
- Offer a specific number of sessions, which often includes DBT
- Work very closely with the MDT – share notes, be transparent, manage capacity together, be a resource to the team, scrutinise the value of what we are doing relentlessly
- Don't expect every referral to proceed to treatment – only around 50% move onto treatment after assessment

There is a caveat though – the scale of the impact is largely down to the discretionary effort of the psychologist herself, who regularly works above and beyond to get the job done. So while the model of working is replicable, the volume is not, and this should be taken into account in future modelling.

In **acute care**, the range of therapeutic interventions declared through resource mapping was the most extensive of any service – around twenty different options are offered. The Clinical Psychologists emphasised the importance of person-centred transdiagnostic working, based around assessment, formulation and intervention which typically draw on motivational interviewing, DBT, CBT, compassion focussed, and acceptance and commitment approaches. The focus is on understanding the contributing factors that brought people to a point of crisis, identifying skills for prevention of further crises, and stabilisation.

Acute Clinical Psychologists have also been proactive in developing group interventions, including a four week programme comprising three

psychoeducational groups per week (currently being evaluated). Sustaining group work can be challenging as it generally relies on an individual practitioner. There is an aim to build up MDT capability to co-facilitate groups, but this is challenging due to lack of protected time for training, supervision, and delivery.

There is no doubt that a huge amount of work is being pursued to tackle access problems, with good effect, amongst the psychological therapies staff on the ground. Many individuals go above and beyond to make a difference. However, we noticed that the sphere of influence for change is too constrained to impact significantly upon the system of which it is a part. In some instances, it may exert greater pressure on the system (e.g. by closing down direct access from primary care to specialist psychological therapies). That system directly impacts upon the work that flows in and out of the specialist function. While there are good examples of wider team impact at individual team level, this is not the norm and it is not part of a bigger plan to make it happen. This means that the full potential of the system as a whole to orientate towards psychologically-informed care is not being realised. This cannot be achieved by specialists alone – it requires an organisational response and commitment.

3.3 Psychological Therapists

At **CMHT** level, most Clinical Psychologists work as single practitioners, sometimes alongside Psychological Therapists. This leaves the service vulnerable to absence (sickness; vacancy; parental leave) as cross-cover is problematic. Staffing by area is reported as follows:

West	3.3wte Clinical Psychologists 1.0wte CBT Therapist
Central	2.4wte Clinical Psychologist plus 0.8wte vacancy 2.0wte CBT Therapists plus 1.0wte vacancy
East	5.8wte Clinical Psychologists 2.0wte CBT Therapists

Numbers in the East have been able to increase to this level as a result of accessing Welsh Government funding opportunities. The skill mix is consistent across the region, in that almost all clinical psychology posts are at Band 8A, with a small number at Band 8C. This has obvious implications for career pathways at both entry and progression stages. There are indications that this is starting to change at entry level, with Band 7 posts being included in funding bids. Psychological Therapist posts are more often at Band 7. Recruitment and retention data were not made available so we cannot comment on specific impacts.

Benchmarking data in Wales is not currently collected so we are unable to set out how BCUHB's staffing compares with its peers. However, the Joint Thematic CMHT Review (2019) was clear in its conclusion that improved access to psychological therapies across Wales requires 'not only increased recruitment in these disciplines, but looking at more innovative ways of meeting this need. Health Boards and Local Authorities must consider identified unmet needs to inform future commissioning and operational plans.' While it is clear that BCUHB's specialist resource is inadequate to meet the needs of the population, it is important to say that the solution to this is not only to increase specialist staffing numbers. The whole system needs to increase its psychological mindedness, capacity and capability in order to address the scale of need. That requires multi-faceted change across all services and the entire mental health workforce as well as primary care, not least in terms of role design, culture, behaviours and interdisciplinary collaboration.

The rurality of the region is a significant draw on scarce capacity, and sparse populations also pose difficulties in terms of critical mass to offer specialist services. It is not realistic to expect every team to provide every therapy, but this does not appear to have been addressed (e.g. by cross team working). Therefore access to therapies depends on the particular skill set of the local team practitioner/s - hence the postcode lottery.

The professional and line management functions for psychological therapies are combined, so while clinicians are based alongside their MDT colleagues, the team managers do not have oversight of their capacity. This parallel management arrangement continues at area and Divisional levels. There is no representation within the triumvirate structure. There are mixed views as to the value of this infrastructure. There are clear signs of fragmentation in working relationships in places, which may in part be attributable to structure, but structure alone is unlikely to be the answer. Creating the conditions for excellent team-based working is more likely to reap the results that are needed (see Chapter 4).

In **acute care**, there are 1.8wte Band 8A posts in West and Central, with a further post recruited to for East, a Band 7 in West, and an Assistant Psychologist in Central. There are 2wte Band 7 vacancies subject to recruitment (as at 31 May 2019). Offering trainee placements allows the team to run groups and increase capacity for individual assessment and intervention, with appropriate supervision. Clinical Psychologists work alongside ward team colleagues but described a culture of 'referring into' psychology, rather than integrated psychological working across the MDT. A handful of nursing staff are DBT-trained but are unable to offer consistent input due to time constraints.

3.4 Training

We understand there is longstanding effective joint working with Bangor University, through the DClinPsych programme, other teaching and research. This is an important and valued relationship. For example, the Older Persons' ward on Anglesey has hosted Applied Behavioural Analysis graduates who have contributed to behavioural assessments and interventions, and enhanced person-centred care as a result.

There is training activity in the Division, with around half the teams reporting imminent training in DBT and to a lesser extent, EMDR. It was encouraging to hear that one of the inpatient Clinical Psychologists, in collaboration with the area Head of Nursing, is co-ordinating a staff survey to establish training gaps and needs at grassroots level. However, while these training priorities are in line with the commitment to trauma-informed care, we were not able to locate a single multi-professional training strategy for psychological therapies across the Division or into primary care. It is not clear how the training needs of the workforce, in relation to the demands placed upon the service and the overarching strategy for attachment-based care, are being planned for and addressed. We understand there was a historical training group across the Division, and that this function has recently been absorbed within the area QSEEL structure. There were consistent comments about lack of training opportunities and funding, including one clinician who is self-funding and taking annual leave in order to study. A *systematic* workforce development approach to enable the delivery of psychologically-informed care by all clinicians was not evident.

3.5 Supervision

There are undated Clinical Psychology Clinical Supervision Guidelines. There is brief caseload review guidance. A supervision audit was not available. It is unclear whether caseload review is a regular part of management supervision, or what happens as a result. We have learnt recently that the supervision guidelines are currently being reviewed and an audit is being planned.

We were reassured that clinical supervision is a core part of clinical practice, and it is job planned for Clinical Psychologists and Psychological Therapists managed under the same structure. Supervision of low intensity psychological interventions delivered by the wider MDT is offered through team Clinical Psychologists, but take-up is mixed, and it is not clear in policy.

Lack of access to supervision in some specific therapies was cited as an obstacle to practice. In acute care, the relatively short time since inpatient posts were introduced was cited as a reason for access to experienced supervision to be limited.

3.6 Audit and Data Collection

It was not possible for us to be provided with any psychological therapies data drawn from BCUHB's patient administration systems, either because it did not exist, or because of significant concerns about data quality. There is no single electronic system across the tiers to enable information sharing or systematic data intelligence, for activity or clinical record keeping. The three BCUHB areas use different systems, none of which are reported to be user-friendly or clinically meaningful. Clinicians reported that they have insufficient admin support to cover demands, and recording Measure information (e.g. care and treatment plans) is prioritised over activity data entry. Activity in secondary care is largely unaccounted for and/or specialist work is 'lost' within overall team activity. There doesn't appear to be a standard protocol as to what should be recorded and where. We were told that the only record of some practitioners' activity is their individual paper diary entries.

An Excel spreadsheet is used to manually capture the waiting time data set required by Welsh Government. A spreadsheet is also used in the East to capture individual clinician activity, but it was not possible to draw any clear conclusions from the data. We understand BCUHB is waiting for an all-Wales digital solution called WCISS.

There is no reliable reported data for needs, unmet needs, caseload, case mix, recovery rates, or outcomes. Outcome measures are used but not recorded anywhere other than the service user's paper record. Examples include BAI/BDI II, BSL 23, PHQ - 9, GAD - 7. Again, there is significant variation in use. Systemic outcome measures in acute settings, which reflect the systemic nature of an inpatient experience, are being explored.

The Interim Head of Psychological Therapies told us that a typical caseload for a clinical psychologist or psychological therapist working full time in an AMH CMHT is around 25 active complex one-to-one cases, with a range of 15-35+. This number will depend on the case mix and complexity of the caseload, and other job-planned commitments such as training and supervision, team consultation and formulation, team meetings and so on. This number does not include those people who are seen for group interventions delivered by Clinical Psychologists or Psychological Therapists, in addition to their one-to-one caseload.

The consequences of this data deficit are wide-ranging. They present significant operational, quality, safety and financial risks, leaving managers and clinical leaders to make under-informed decisions about how best to allocate very scarce resources and mitigate risks. We are not entirely confident that there is sufficient insight into these risks and consequences, or the part they play in the narrative that surrounds psychological therapies. While we were told that conversations have been happening for some time internally as well as

nationally, including an all Wales Informatics Workshop in June 2019, we observed little conclusive remedial work within any part of the organisation as yet.

4. Common Challenges in AMH Psychological Therapies

Across all tiers, there are consistent challenges about the design and delivery of the model:

- Services across the stepped care model exist, but they are fragmented and do not come together as a coherent whole. There is no standard operating procedure or integrated care pathway. This vastly undermines the scope of stepped care to deliver its potential gains, including ‘right care, right place, right time’. It means capacity is not managed across the whole system, and so bottlenecks between services become inevitable.
- Minimum service delivery expectations, in line with stepped care, are not defined. Individual services make rules unanimously, in an attempt to maximise the impact of the resource they control, as a coping mechanism in an under-resourced system which is incentivised to deliver quantitative results. The consequences for service users include the postcode lottery, and that they are subjected to a ‘game of snakes and ladders’, as one provider put it.
- Relationships between tiers are similarly fragmented, particularly where different providers are involved. Staff do not work across tiers – e.g. to provide supervision and support. There appears to be very limited contact between psychological therapies at tier 1 and tier 2.
- Relationships between MDT members are sometimes negatively affected by structures and processes that deter joint working.
- Services have been developed in piecemeal ways, often in response to specific failure demand somewhere in the wider system. Strategic commissioning is not evident. There is no clear fit or flow across a single integrated pathway. Additional services have been bolted on to Tier 1 rather than integrated. The map of provision looks different in different places.
- While the third sector is fully engaged in direct service provision, its assets and potential seem largely unrecognised and untapped in the wider system. Reaching out from specialist services to build community capacity and capability for psychological resilience is an opportunity waiting to be grasped. This is in line with Welsh Government expectations set out in *A Healthier Wales* (2018).
- This lack of coherence is evident at every interface, each one becoming a bottleneck for people to wait. There are significant gaps between thresholds for services, and lack of clear criteria as to what needs should be met where and by whom. There is significant duplication of work at

different tiers, through lack of joint working (e.g. separate assessment processes; separate clinical notes). Tier 1 reports holding onto people for longer than it is designed to do 'because there is nothing else'.

- A lack of psychological mindedness across the workforce is generating additional need in the population, and additional demand upon specialist staff. Low level interventions, delivered by a wide range of mental health professionals, are not embedded within the core mental health offer. This is attributed variously to lack of focus, time, skills, and awareness of what is possible. In short, the system is not geared for therapeutic intervention.
- Standardised data to understand what is happening in services is not routinely available, and data to understand the whole picture is not integrated or collated. This leaves objective and well-informed decision-making wanting. Data used for contract monitoring appears to be provider-driven, and misses opportunities to 'join the dots' with the bigger picture.
- Considerations about equality of access for specific groups are overshadowed by the many other access challenges.

Key Questions Specific to AMH

- What is our core offer? Are our AMH resources aligned in such a way to deliver that core offer?
- How can we realise the full potential of the stepped care model across all services and tiers?
- What measures do we need to take to 'right size' our demand and capacity, including tackling the legacy waits?
- What can we do to improve our culture and capabilities around intelligence-driven decision making, while we wait for WCCIS?
- How will we devise a strategic approach to building capacity and capability in our multidisciplinary workforce across the region, making full use of opportunities to work better across all services and specialties, in order to offer psychologically-informed care to all?

5. Older People's Mental Health Services

'There is more we can do to influence the broader system by working together.'

1. In Brief

In Older People's Mental Health services, there is a specialist model for psychological therapies, with limited low intensity interventions delivered by other clinicians. This is attributed to a lack of infrastructure (training, supervision etc.) as well as capacity. Clinical Psychologists are highly valued by their MDT colleagues. There is a workforce of less than 7wte for an over 65s population of nearly 158,000 (c.23% of the total population), which is widely dispersed geographically. Services lack the critical mass required to sustain core functions, resulting in specialists being spread very thinly across areas and responding as best they can to need as it arises. For example, the Memory Service in the East area reported being without a psychologist for two years. Waiting times vary widely between areas, from two to fifteen months. There is a desire to move towards a more strategic approach to planning and delivery of care. Despite significant service pressures, Clinical Psychologists contribute extensively to professional and service developments locally and nationally, and to training, in close collaboration with Bangor University.

2. Psychological Therapies Model

Primary Care

Primary care services were consistently described to us as extremely limited and significantly under-resourced for the level of need. There was just one response to the resource mapping exercise from an OPMH Primary Care Team (Wrexham), which consists of one RMN.

Secondary Care

The OPMH community service model in secondary care varies across area, with an organic (dementia) service in the West, an over 65s mixed functional and organic service in the East, and a blend of the two in Central. This is a legacy that pre-dates the creation of BCUHB. We understand this is subject to review currently via the relevant Quality and Workforce Group. Practice between areas is also reported to be variable, and a desire to see a clearer strategic approach across the region was expressed. Views were expressed that over 65s with functional needs were not well met as they often don't meet the thresholds for input, alongside younger adults. There is no dedicated input for young onset dementia, so provision is ad hoc and reactive.

All Clinical Psychologists within the services work within the CMHTs and/or Memory Clinics. Some work across areas to provide cover. Capacity is described as extremely stretched, and varies between areas. Inpatient psychology roles are

shared with AMH. Services are provided from a wide range of inpatient and community settings, as well as the person's home or care home.

Integrated Team Working in Wrexham and Flintshire

Motivated by the desire to spread the impact of a psychological approach beyond individual therapy, the Clinical Psychologist for the East area came into post understanding the importance of working with the wider team, to develop mutual expectations of the value she could add. She has pursued this goal of collaborative working in several ways:

- attending team meetings for MDT discussions, enabling psychological perspectives to inform care planning even where no direct referral has been made
- working alongside CPNs, OTs, and Consultant Psychiatrists in case discussions and joint appointments
- being co-located with other team members, which enables easy liaison and relationship-building
- organising teaching sessions, offering supervision and facilitating a monthly complex case discussion group. The latter provides space for clinical discussion and team formulation, as well as important reflection about the emotional impact of work upon clinicians

All of these things contribute to building the psychological mindedness and capabilities of the team as a whole, something which is especially important when the Clinical Psychology input is spread thinly between two teams.

Key to this success has been the freedom to develop the role in this way, as well as fantastic support from team managers.

3. Psychological Therapies

Primary Care

The Wrexham primary care nurse reported that she offers web-based psychoeducation, self help, supportive counselling and watchful waiting. Most people are seen within six sessions.

Secondary Care

Clinical Psychologists in secondary care provide clinical, neuropsychological and behavioural assessments, generate clinical formulations and carry out interventions with the person and their family or carer network. The range of therapies available includes CBT, EMDR, mindfulness-based therapy, acceptance and commitment therapy, relapse prevention and systemic interventions, but this varies according to team. Work is individual- and group-based, as well as consultative with the wider team. Through the resource mapping exercise, staff

reported that some skills are under-utilised due to service pressures and ways of working.

Access to therapies varies widely across the region, largely according to resource availability. Waiting times for psychological interventions vary from two to fifteen months, for both organic and functional needs. Memory assessment waits are shorter, at around one to three months, due to the time-limited nature of the service.

The breadth of people, professionals and services involved in supporting people with dementia brings a unique complexity and nuance to work with this client group. While memory clinic assessments may be the most tangible currency for modern service delivery, it is vital to appreciate the intricacy of the multi-disciplinary work required to support someone from pre-diagnosis onwards, and the role of psychological interventions in ensuring a high quality and evidence-based approach.

4. Psychological Therapists

There are 6.9wte members of qualified staff to serve the population and geography of North Wales (headcount n=11). Information from the resource mapping is limited but appears to indicate a flat skill mix, with most posts at Band 8A. All are HCPC-registered, and several hold membership of relevant professional bodies such as the British Psychological Society. As integral team members, Clinical Psychologists play a key role in service developments, for example in securing accreditation and re-accreditation with the Royal College of Psychiatrists Memory Services National Accreditation Programme since 2015. The Head of Service also sits on the MSNAP Advisory Panel, the Public Health Wales Memory Assessment Service Sub Group, and the National Steering Group for MH&LD Dementia Care.

Additional funding from Welsh Government has been secured less often than in AMH, although 3wte inpatient posts shared with AMH have been introduced in recent years, and three more are in the pipeline.

5. Training

Training is provided to those who are involved with supporting the person, whether they are family members or formal care givers, within and beyond the NHS.

There are strong links with Bangor University, supported by a joint appointment between BCUHB and the North Wales Clinical Psychology Programme. Around ten clinical trainee placements are offered every year. Staff provide training and supervision to the trainees, and several teach on the programme as well as undertake other academic duties.

Links are also being developed with Bangor around Applied Behavioural Analysis, including a successful bid from the Integrated Care Fund for an ABA practitioner.

Clinical Psychologists also provide training to their MDT colleagues.

6. Supervision

Clinical Psychologists provide supervision to MDT colleagues, and are also available for consultation. They supervise trainee Clinical Psychologists.

The same undated Clinical Psychology Clinical Supervision Guidelines are in place as for AMH. A supervision audit was not available to review, but supervision was reported to be in place and job planned.

7. Audit and Data Collection

The primary care nurse in Wrexham uses PHQ9 and GAD7 outcome measures, which are routinely recorded in clinical notes.

From the two secondary care OPMH responses to the resource mapping, we established that:

- One team reported the typical number of sessions as thirteen or more in most cases, whereas the other reported a greater range from seven to more than fifteen.
- One team reported use of CORE, BDI, HADS, GDS, and BAI outcome measures, while the other reported that none were in use.

The position in terms of electronic data management is as inadequate as it is in AMH.

Clinical Psychologists are well-engaged with the University's research programme.

We were told that audit feeds into the QSEEL governance processes.

Overall, OPMH psychological therapies appear to work effectively and proactively alongside the multidisciplinary team, and are fully engaged with Bangor University. However, there is scope for greater integration of psychological work across the clinical workforce, if the infrastructure and capacity allowed. The limited resource mapping data suggests there is variation in working practices as well as access to therapies. The most significant concern is the very small specialist capacity, which hampers direct and indirect clinical service delivery and developments, as well as career opportunities.

Key Questions Specific to OPMH

- Resources for psychological interventions at general and specialist levels are inadequate for the local population and its nature. Can we do anything more to maximise the impact of what we have, and how should we best target any new investment?
- How can we increase access without sacrificing the quality of what we provide in an often complex clinical picture? What is our understanding of the variation in practice across the region?
- What opportunities are there to strengthen joint working with other specialties?

6. Substance Misuse Services

'We started with a blank sheet. There was freedom to do something different.'

1. In Brief

Capacity for specialist psychological therapies in SMS has always been very small, and so when it was established, it cut its cloth accordingly. We heard consistent examples of psychologically-informed working across the MDT, backed up by targeted use of the clinical psychology resource in support of the wider team. There is much learning to share with others, particularly around maximising the impact of resources and growing capacity for psychological interventions. SMS is role-modelling much of what is advocated for AMH and OPMH in terms of improving access, but there have not been opportunities or time to share this learning.

The specialist service is underpinned by third sector provision in primary care.

2. Psychological Therapies Model

Primary Care

CAIS, a local third sector provider, is commissioned by BCUHB to provide a well-established SMS Counselling service at Steps 1 and 2, working with people who are using at a 'hazardous and harmful' level rather than 'dependent'. It receives around 500 referrals per year (2017/18), with around three quarters relating to alcohol and a quarter to drugs. Target times for assessment are met in around 75% of cases, and for treatment around 80%.

In Wrexham & Flintshire only, there is a Therapeutic Intervention service, commissioned outside the NHS by the Area Planning Board (APB) and handling around 600 referrals a year (2017/18). It sits between Steps 2 and 3, providing extended brief interventions for people with mild to moderate mental health and substance misuse needs (up to twelve sessions, but typically three to seven). It works closely with the SMS Counselling Service.

The Psychological Therapist employed by BCUHB runs weekly outpatient clinics for Gwynedd, Anglesey and Conwy, responding to common mental health needs, which very often underlie addiction. This CBT provision is funded by the APB.

This leaves Denbighshire with a counselling service only.

CAIS has a solid data set of performance metrics for the services, and shared some positive case studies that described users' experiences. What is not clear is if/how the provider and commissioners have worked together to use this information to improve pathways and maximise impact across the full spectrum of demand. The current picture appears to be determined more by history than design.

Secondary Care

Psychological therapies in SMS are fully integrated through necessity as well as desire – with just 0.7wte Clinical Psychologist (capacity around six sessions per week for one-to-one work) and 1wte Psychological Therapist (around twelve sessions per week), it has never been feasible to offer a traditional model based on one-to-one work. As the first and only Clinical Psychologist, the Lead was able to set these expectations from the outset, rather than having to unravel established practice that had become unsustainable - a key point to appreciate when comparing with other specialties. This approach complemented the service's ambition to move beyond a solely medical approach to substance misuse treatment.

The service is made up of six county-based teams in North Wales, with a total caseload of over 2000 people. The wider team has been keen to work in psychologically-informed ways and the resource has been organised to enable this.

The model consists of a range of group-based structured interventions, facilitated by care co-ordinators, the (temporary) assistant psychologist, or peers. This leaves the Clinical Psychologist to focus on consultancy, supervision and training to the team (alongside a reducing volume of one-to-one work), which ensures quality is maintained across the board.

There is very little joint work undertaken with AMH clinically or strategically, despite service users often accessing both services. A co-occurring pathway as defined in the Welsh Government Service Framework (2007) is not in place. This is seen to be as a result of lack of engagement from AMH, through lack of time and opportunity to come together.

3. Psychological Therapies

In primary care, therapies include motivational interviewing, CBT and relapse prevention therapy.

CBT is used widely for evidence-based treatment of common mental health disorders by the Psychological Therapist. Many people suffer with PTSD and so EMDR is widely practised.

Therapies in secondary care consist of a range of evidence-based psychological interventions and treatment, including CBT, group CBT, EMDR, ACT, relapse prevention and motivational interviewing. Waiting times for the service as a whole are growing, and access to groupwork varies by area, according to the frequency with which each group runs.

Group-based interventions are manualised and include *Nudge*, *Moving On In My Recovery*, and *Pathways To Recovery* (which is ACT-based). *Moving On* has been

developed with peers, and is co-led. It is designed to bridge the gap between complex needs and moving on, so there is a clear pathway out of services which joins up. There is a sound evidence base for the use and validity of peer support in SMS.

4. Psychological Therapists

Primary care capacity for Substance Misuse counselling is integrated with CAIS's Parabl staffing (see p23). Specialist capacity is as described above.

5. Training & Supervision

A gradual programme to train every secondary care clinician in *Moving On* and *Nudge* is underway, to support all staff to use the skills in their daily work. Around half of the clinical workforce (circa 30) have completed their training, which takes four days for *Moving On* and 1 day for *Nudge*. They are included in the service's training matrix and made mandatory for completion every three years.

Twelve staff are undertaking training in Acceptance and Commitment Therapy currently.

The Clinical Psychologist provides training and supervision to the wider team. He also has a role with Bangor University. However, he is isolated professionally, and there does not appear to be a forum across the Division to support professional development and peer support.

6. Audit and Data Collection

In primary care, AUDIT is used and recorded on a CAIS database.

In secondary care, Treatment Outcome Profile (TOPS) data is routinely captured and reported. Pre- and post-measures of effectiveness are in place for CBT sessions, group outcomes are recorded in psychology notes (e.g. recovery strengths questionnaire), and there is some audit activity. We understand there is a discussion taking place with the Area Planning Board to support an additional role for governance and training.

Overall, SMS in secondary care models a contemporary approach to the delivery of psychological interventions which maximises the value of the resource across the multi-disciplinary workforce, thus enabling a psychologically-oriented offer for all service users. Nevertheless, the whole system (across all steps) is neither right-sized (demand outstrips capacity) nor equitable across the areas. Thus there is value in looking strategically and operationally at opportunities for closer working between primary and secondary care to manage demand and capacity more effectively. This may reveal the need for pathway/service redesign in Steps 1 and 2.

Key Questions Specific to Substance Misuse Services

- What can we do to tackle pathway inequalities across the region, and strengthen a whole system approach to managing demand and capacity? What is needed to improve our focus on value for money across all steps?
- How can joint working between SMS and AMH be strengthened, in order to improve services for people with co-occurring mental health and substance misuse problems?
- What opportunities can we create to ensure there is accessible professional development and peer support available to smaller speciality clinicians, and to enable sharing of good practice and learning across specialties?
- Is it a priority to invest in reducing waiting times, and if so, what is the scale of the requirement?

7. Forensic & Rehabilitation Services

‘There’s lots of opportunity to look at the whole system and see psychological interventions at the heart of every person’s recovery and rehabilitation.’

1. In Brief

Clinical Psychologists in Forensic and Rehabilitation services work closely with their multidisciplinary colleagues, but this has not translated into the sustained development of psychological capability and capacity across the multidisciplinary workforce. This is attributed to a lack of protected time for nursing staff, working in inpatient settings, to develop and practise the necessary skills, and to receive supervision. There are very significant gaps in the overall pathway of local services, meaning there is no continuity available to service users working with psychologically-based care plans. Specialist staffing resource in rehabilitation is particularly scant, and there are competing pressures to be involved in service developments as well as deliver clinical care. There are many opportunities, and plenty of enthusiasm, to look more strategically at the potential of psychological therapies to enhance pathways and ensure more timely outcomes for service users. Excellent examples of this potential have already been achieved, including the *Life Minus Violence* programme, and the specialist skill mix changes in Forensics to increase access to graded therapeutic interventions. There is also significant potential for psychological therapies to contribute to strategic pathway improvements across Forensic and Rehabilitation services.

2. Psychological Therapies Model

Psychological therapies provision for people on a forensic pathway is provided entirely within the medium secure inpatient setting, Ty Llewelyn. There is no commissioned provision within the community forensic team, so upon discharge from secure care, psychological input stops.

There are no inpatient secure services locally for women, and no low secure care for either men or women. These are very significant gaps in local pathways that hinder repatriation and risk extending lengths of stay in restrictive environments, with knock-on consequences for rehabilitation. This situation appears to be at odds with the equally significant drive to repatriate people from high to medium security. These gaps have implications for the sustainability of psychological work achieved in medium secure care – e.g. because psychological input ceases entirely, or continuity of care is broken and new therapeutic relationships have to be established.

The rehabilitation service comprises four inpatient facilities and two community teams, and is covered by one clinical psychologist. Inevitably, this means that

there is unequal access across the services. It is subject to a separate review process.

3. Psychological Therapies

The team provides specialist clinical psychology input on an individual and group basis to address the complex mental health and offending presentations of the client group. It has developed a highly effective *Life Minus Violence* strengths-based CBT programme, made up of seven modules delivered weekly over 18 months. It is delivered by Clinical Psychologists and nurses working together.

There is a DBT team in place, led by Clinical Psychologists and co-facilitated with DBT-trained nurses. As such, pressures on the wards make it difficult to sustain, as time is hard to protect when the nurses work 'in the numbers'.

Other therapies offered include CBT, CBTp, functional remediation, relapse prevention, trauma-informed therapy and cognitive remediation therapy.

We were told about occasional situations in which specialist psychological therapy is accessed and funded out of area (sometimes necessitating inpatient care), because there is no local capacity available to provide it. It wasn't clear to us how decisions about priority allocation of capacity are made, except that operational managers don't appear to have a role to play in the decision-making.

4. Psychological Therapists

The forensic team comprises 1wte band 8C post and 2wte assistants, while in rehabilitation there is 1wte band 8C. This small team is overseen by 0.8wte band 8D lead post. Inpatient forensic capacity has recently been remodelled through a skill mix review to enhance a graded approach to psychological interventions, particularly ward-based group interventions. This is being trialled on a 12 month basis initially.

In rehabilitation services, the clinical psychologist has focused her attention, out of necessity, on the 'locked rehabilitation' ward, undertaking complex assessments and delivering individual interventions, while also supporting the wider team in a formulation-oriented approach to better understand the needs of the client group. A number of nursing staff have undertaken training to varying levels in DBT and CBT. However, this still leaves significant gaps in psychological assessment and intervention for service users in the other rehabilitation services – an inequality that is designed into the system through lack of adequate staffing to provide direct and indirect care.

Over the last year, a fixed term assistant post has been in place, focussing on service development and pathway review, in the context of significant demographic and risk profile changes amongst this client group. The funding has been extended for a further year.

The Lead is keen to extend opportunities for all clinicians to work in psychologically-minded ways (e.g. to use psychological interventions in group settings for relapse prevention, CBT for anxiety and depression), with Clinical Psychologists providing support and consultation.

5. Training and Supervision

Both forensic and rehabilitation services are keen to see greater multidisciplinary expertise in psychological interventions, supported by appropriate training and supervision from specialist clinicians. While some of this expertise already exists, the main barrier to its use is protected time. Relevant staff do not have job-planned time to deliver this work, and so there is a longstanding problem with competing priorities, with real time ward pressures taking precedence. This means psychological interventions are not offered consistently, or across all teams.

Given the prevalence of trauma experiences within this client group, and the impact of these experiences on recovery, there is also a desire to expand capacity for EMDR.

In forensic services, eleven staff are due to be trained in *Moving On In My Recovery* (ACT and MI based), which has been successfully developed in SMS for use with individuals with a history of substance misuse.

In rehabilitation services, one member of staff is starting an art therapy course.

6. Audit and Data Collection

There are three different electronic data systems in use across the services, but they are described as being of limited use. Audit work requires additional manual review of case notes, and hence is very time consuming for a very small workforce. As a result, audit activity is limited.

In terms of service user feedback, a satisfaction audit was last undertaken in 2015. Feedback is also collected following group interventions, in addition to pre- and post-measures. As numbers of service users are low, the data set is still in development. Also, the assistant psychologists are involved in facilitation of the Together 4 Recovery service user forum.

Overall, the potential value that psychological therapies in Forensic and Rehabilitation services can add is significantly hindered by the lack of continuity between different elements of the pathway, and by the inherent challenges of protecting time for nurse colleagues in inpatient settings. Specialist staffing resource in the Rehabilitation services is inadequate. As a result, psychological approaches do not yet underpin the model of care. There are very positive and proactive developments in place (e.g. *Life Minus Violence* programme), but a

more strategic approach, appropriately resourced, would accelerate improvements in outcomes for both service users and the system as a whole.

Key Questions Specific to Forensic & Rehabilitation Services

- How might pathway improvements to repatriate local people to their local communities be accelerated by strategic investment in psychological therapies (e.g. to influence and support service development; to reduce lengths of stay; to increase independent living skills; to sustain progress upon discharge; to support capacity building in the third sector; to *rehabilitate*)?
- Does the existing review of rehabilitation have sufficient priority within the wider Division?
- How might the wider workforce be enabled to develop skills in psychological interventions, to strengthen further the graded approach and enable best use of specialist skills and capacity?

8. Learning Disabilities Services

'Get it right for people with a learning disability and you get it right for everyone.'

1. In Brief

The commitment to fair access for all people is explicit in the local Together for Mental Health strategy, while the detail around the future of Learning Disabilities is covered within a separate but aligned strategy. However, services have evolved over time in a context in which reasonable adjustments for the needs of people with a learning disability have not been made. This has meant that LD services have sought to compensate for this, in order to mitigate the consequences of inequitable access to other 'non-adjusted' services. We saw compelling evidence of integrated working, creative responses to meeting the highly individual needs of the client group, service developments both internally and externally, and a keenness to strengthen interface working with other specialties. There is potential to extend the impact of psychological approaches by developing specialist capacity and capability locally, to respond to those with the most complex needs without recourse to out of area provision.

2. Psychological Therapies Model

It is reported to be very difficult for people with a learning disability to access other health services, including AMH. Reasonable adjustments are not made, and there is a widely-held view that the LD label throws up barriers to access, based on stigma. As such, psychological therapies in LD have responded to this lack of access through necessity.

In this context, the notion of a primary/secondary care divide is not particularly meaningful. There is no specific LD provision in primary care, although theoretically there is no reason for people with LD to be excluded from the existing primary care mental health services. In practice, it is likely that someone with an identified LD would be referred to the specialist teams.

Community LD teams at locality level are hosted by the relevant local authority in an integrated health and social care structure. Psychological therapies staff are a central part of each team. There is one inpatient psychologist, covering various units at Bryn Y Neuadd Hospital and the community rehabilitation team.

Clinical Psychologists work as core team members, and the focus is on the team agenda. Referrals are made to and owned by the team – there is no 'referring into' psychology. This scale of integrated working is the result of many years of work to embed Clinical Psychologists within the core team.

Access to suitable space for people with LD is limited and means that staff spend a lot of time travelling across the rural geography of North Wales.

Operational managers work closely with psychologists to manage team capacity. There is a Psychology Lead for the service as a whole, who focusses on complex needs and ASD developments, as well as providing consultation and supervision to the wider team. He described a culture of working together, anchored in shared values that are all about the individual – ‘we don’t pull rank’. The Lead is a full member of departmental groups such as the Senior Leadership Team meeting, Team Managers meeting, QSEEL, and the wider Psychology Heads of Service meeting.

In the absence of any local provision for the people with most complex needs, a significant number of local people receive high intensity/high cost inpatient care out of area. There is the potential for Clinical Psychologists to make a major contribution to the development of local services capable of responding to forensic and challenging needs, with upfront resource on an ‘invest to save’ basis. This opportunity doesn’t yet appear to have been grasped in the organisation.

3. Psychological Therapies

LD clinicians described the importance of appreciating the evidence base in the context of the very specific and unique circumstances of each of their clients. The complexity of an individual’s needs may mean that condition-specific interventions are not indicated. Where assessment and formulation suggest they would help, the literature is of limited use, as evidence has often been developed with other client groups in mind. So the clinical psychologist will adapt the approach according to the individual, while recognising this may impact on the effectiveness of the intervention.

The work includes:

- Dementia assessment, diagnosis and care planning - at local and policy levels
- Diagnostic assessment for eligibility – a new piece of work to formalise an evidence-based process, including support team colleagues in the application and interpretation of assessment for eligibility.
- One-to-one therapeutic work, including care co-ordination and risk assessment, with people with complex needs. Assessment and intervention often systemic in nature, given the support networks that are needed for this client group.
- DBT was developed and adapted for people with a learning disability, and ran for around two to three years. Unfortunately, it was not possible to sustain this development and it has ceased due to resource constraints. It was very challenging, across a dispersed rural region, to assemble a critical mass of people in one place for a DBT skills group.
- Autistic Spectrum Disorder diagnostic assessment.

- Integrated autism service – LD Clinical Psychologists played a key role in the development of this service, and contributed to national developments in this field.
- Offending work, including use of assessment tools such as HCR-20.
- Capacity assessment, including s49 reports.
- Challenging behaviour functional assessment, and support to other team members.

The resource mapping data indicated that therapies include CBT, DBT, CAT, MBCT, schema therapy, family intervention, applied relaxation and relapse prevention. In addition, there are three programmes tailored to client needs – *Soles of Their Feet*, *Beat It*, and *Step Up*. The range available varies between teams. Some respondents indicated that constraints include time and physical space to see clients.

It is generally expected that therapy length will be longer than the general adult population. Responses from the six teams who participated in the resource mapping exercise show this to be broadly the case, but it is interesting to note a marked variation in the typical number of sessions across different but comparable LD teams.

4. Psychological Therapists

The workforce of 7.9wte is made up entirely of Clinical Psychologists, who work as care co-ordinators where it is appropriate to do so. Work to extend psychological intervention skills to the wider team, particularly nurses, is underway. In the inpatient services, four nurses are trained DBT therapists. Community teams include some staff who are trained in specific approaches – e.g. *Soles of Their Feet* programme. There is at least one DBT-trained nurse.

There are limited opportunities for career progression, as all Clinical Psychologist posts (6.9wte) are banded at 8A (except the lead 1wte Band 8D). This has several implications. It leaves a significant retention risk for experienced staff, it prevents delegation of developmental opportunities by the Lead, and it precludes the development of service-wide clinical specialisms which could impact positively on strategic aims (e.g. services for people with complex needs in high cost placements). The rationale for this skill mix is not clear, but it appears to have come about through removal of posts at Band 8B and 8C, either through cost savings or redistribution of resource elsewhere. This leaves particular staffing pressures in the West area.

5. Training

Several respondents to the resource mapping described difficulties in accessing training opportunities (time and funding). Two teams reported training in the pipeline (ACT and Behaviour Science).

Clinical Psychologists are involved in training colleagues in the wider MDT.

They also play a full role in teaching and development of the North Wales Clinical Psychology Programme with Bangor University, and routinely host trainee psychologists on placement.

6. Supervision

All professional and managerial supervision is provided by the Head of LD Clinical Psychology, as a consequence of the flat skill mix. Anecdotal evidence indicates that supervision is accessed around 10 times a year, for an hour and a half each time. This is soon to be audited. Supervision is also available via DBT consult groups and there is an option to meet for peer supervision monthly.

7. Audit and Data Collection

Again, there are wide-ranging examples of involvement in this domain:

- Clinical Effectiveness Groups have been designed and developed to review existing best practice and evidence, and then bring it to life through pathways and processes for service delivery. Clinical Psychologists are closely involved and chair three of the four groups.
- Some teams report the use of outcome measures, including PTOS, where it is meaningful in the client's circumstances, e.g. those who use the service on a long term basis. Feedback is also sought.
- NICE guidelines audits have been undertaken.
- Needs mapping is being undertaken to look at specific needs (e.g. offending behaviour)
- Support provided to nursing colleagues to participate in relevant externally-funded research projects, including the largest therapeutic Randomised Control Trial ever undertaken within LD.

In terms of electronic data management, psychologists use the system of their host Local Authority, so these differ across the region and are not those used in BCUHB.

Monthly referral data by psychologist is collected. There is no infrastructure to collect or analyse data about waiting times. However, we were given reassurance that working practices are such that urgent needs are responded to urgently. The team approach is key to managing capacity in this way.

Similarly, there is no data available about unmet need.

There is a process to seek client feedback about their experiences of Clinical Psychology, where appropriate, at the end of treatment. A recent analysis of feedback forms indicated positive feedback to over 90% of the questions asked, with the most significant negative response relating to understanding letters

written by the psychologist. The analysis also highlighted some difficulties with implementation of the feedback process, which are being addressed.

Overall, psychological therapies in Learning Disabilities services demonstrate effective integration within a multidisciplinary service model, and an innovative approach to making the most of the resources available. There is reported evidence of wide-ranging developments at local and national levels, and with the university. Access to other health services is consistently cited as a longstanding problem, and variation in access and practice between different areas is apparent. Like most specialties, there is a flat skill mix which impacts on career opportunities, retention and specialist capability building. There is an important opportunity to grow local capacity and capability in complex needs management, to help people to stay closer to home and to deliver cost efficiencies to the health economy.

Key Questions Specific to Learning Disabilities Services

- What are the respective roles and responsibilities of mental health and LD services for people with a learning disability? How do they fit together to ensure equality of access?
- What resource is needed to better enable delivery of those roles and responsibilities, and how can we work creatively with other specialties to manage resource constraints?
- How can we shape and resource a piece of transformation work aimed at repatriating people with the most complex needs, with clinical psychology contribution at its heart?
- How can the career pathway for LD Clinical Psychologists be developed, and simultaneously improve the use of existing workforce skills towards the system's biggest challenges?
- How can opportunities for shared learning be improved, particularly around the experiences of developing effective integrated team working?

Working in Teams

'Integrated care is only possible if the divisions created by professional specialisms are transcended' (McClean, 2005).

1. Overview

For many years, the organisation of contemporary mental health services has been formed around the idea that high quality care requires input from a range of disciplines, expertise and theoretical bases, in order to meet the diverse needs and expectations of service users. Examples include community mental health teams, mental health legislation, national policy and best practice (e.g. NICE guidance).

The practice has proven much harder than the rhetoric. One reason for this is that there is not a shared professional narrative for understanding mental distress. Perspectives differ between professions, as do language and emphasis. This gives rise to behaviour and practice intended to preserve professional identity and uniqueness, in response to a sense of threat.

Working together – between professionals, between primary and secondary care, between specialties, between acute and community services, between the NHS and its partners, between the NHS and the people it serves – quickly emerged as one of the most significant themes of this review. Opinions, experiences and narrative were diverse. The desire for better integrated working in the interests of service users and carers was consistent. So this chapter is dedicated solely to the issue of working effectively in interdisciplinary teams. What does the evidence say, and how might it relate to people working in or accessing services in North Wales?

N.B. This chapter draws mainly on three sources – Effective Teamwork (2012) by Michael West, Interdisciplinary Working in Mental Health Care (2012) by Di Bailey, and guidance published by the Division of Clinical Psychology. It is not a full literature review, but it provides a reliable basis for appreciating the evidence base around team-based and interdisciplinary working.

2. The Basics of Team-Based Working

Professor Michael West's research on **team-based working** and compassionate leadership is well-recognised across the NHS. Many of his findings are consistent with those of Professor Amy Edmondson (Harvard Medical School) around team working and psychological safety.

West describes teams as having no more than twelve members, and three core components, all of which are necessary for effective functioning:

- Shared objectives (we are working towards the same thing; we understand our precise roles and responsibilities)
- Interdependence (we need each other to succeed, because we can't achieve our objectives alone)
- Reflexivity (we meet regularly to consider how we are performing and what we need to do differently)

Conflict emerges in circumstances where:

- Roles are not clear or mutually understood
- There is no clear, shared vision and goals, so tasks are individually determined rather than collectively owned
- Resources are inadequate for the task
- Work is allocated and rewarded on the basis of function (discipline), rather than there being collective responsibility for the 'end product'
- There are inconsistencies in status between team members
- Authority is overlapping
- Team members don't feel able to rely on their colleagues and, as a consequence, their own effectiveness is affected
- Ways of evaluating success are not compatible

It is West's view that the majority of workplace problems that manifest as interpersonal in nature are actually rooted in structure and process. In other words, the system is capable of generating the conditions for conflict within its design and operation, regardless of the current set of individuals involved within it. This systemic understanding of conflict, and its interaction with staff engagement, is often overlooked in organisations.

West's evidence highlights some stark **consequences** of ineffective teamwork upon the quality and safety of services:

- Higher patient mortality rates
- Lower patient satisfaction
- Higher error rates
- Lower job satisfaction
- Higher staff turnover and sickness absence
- Lower staff engagement

For teams to function effectively, they need a number of things from their organisation:

- *Targets*, determined collaboratively, which make explicit what it required of the team, in measurable terms

- *Resources*, sufficient to deliver the agreed targets (e.g. staffing numbers and skill mix, funding, technology, accommodation)
- *Information*, about what the organisation's strategy is and how the team relates to it
- *Education*, relevant to the team's role and task, regularly updated in line with professional requirements
- *Feedback*, which is accurate, timely, and useful to improved performance
- *Technical and process assistance*, to support the team with skills and expertise which are not core to the team but are essential to its effectiveness and development

3. Interdisciplinary Working in Mental Health

McClellan (2005) makes a distinction between two forms of practice:

- Multidisciplinary – 'a team of people working together but maintaining their professional autonomy', and
- Interdisciplinary – 'a team of professionals working as a collective'

Multidisciplinary practice is entirely capable of being fragmented. At best it has an additive effect. Interdisciplinary practice relies on collaboration, which strengthens the contribution of individual team members and has a multiplicative effect (the whole is greater than the sum of its parts).

Features of interdisciplinary working include (Miller & Freeman, 2003):

- A meaningful and embedded vision of teamworking
- A shared philosophy of care, which facilitates shared responsibility for delivery
- All team members are involved in problem solving and decision making
- Team members have a deep appreciation of each other's roles and underpinnings
- Team members learn new skills from each other in order to contribute to continuity of care
- Joint practices are in place – e.g. assessment, monitoring, evaluation

The difference between interprofessional and interdisciplinary working is the extent to which service users are regarded to be part of the team, actively participating in their own care. The interdisciplinary approach complements the biopsychosocial understanding of distress. It must be the organising principle for recovery-oriented practice, in which it is the individual, not any one professional, who defines what their recovery looks like – their 'life beyond illness'.

Bailey (2012) describes three dimensions of interdisciplinary working in specialist services:

- i. *Organisational* – the strategic context will impact upon what is possible to achieve at team and practice levels. In other words, the organisation has a fundamental role in helping or hindering interdisciplinary working. Examples include mission and vision, planning priorities, financial systems, accountability, processes and procedures, and opportunities for service user engagement.
- ii. *In teams* – in order to practise in ways which align with organisational priorities, teams need clear lines of communication and agreed referral routes and pathways. Team members should play a part in defining the measures by which their performance will be judged. Examples include consistent ways of working within and across teams, management and supervision arrangements, a psychologically safe team culture, and an appetite to challenge processes which exclude service users.
- iii. *Practice (individual)* – clinicians are sufficiently confident in their own professional identity and contribution that they are comfortable with (not threatened by) increasingly flexible boundaries. Integrated care planning processes are clear and consistent. There is a shared understanding of both mental distress and the value of the collaborative approach to service users.

In the primary care context, Bailey *et al.* (2012) stress the importance of embedding primary care within a whole systems approach to mental health care. Across the three dimensions above, this looks like:

- i. *Organisational* – policies and practices which enable interdisciplinary working (e.g. communication and information sharing); shared biopsychosocial values; interdisciplinary learning opportunities which include service users
- ii. *In teams* – co-location; shared record-keeping; clear roles and responsibilities
- iii. *Practice* – the service user is central to care planning across all services; there is easy access to specialist consultation

The challenge for managers of interdisciplinary services entails the operationalisation of the shared vision and mission. **Where team strategy, operational policies and practices are at odds with the vision, fragmentation and professional protectionism are the inevitable consequences.** ‘The process of managing change in interdisciplinary working ...hinges increasingly upon effective human interaction alongside the successful management of resources and service redesign’ (Bailey, 2012).

The Role of the Clinical Psychologist in the Team

The strategic value of ‘talking therapies’, for health, wellbeing, and therefore employability and social inclusion, has underpinned key mental health strategy and policy in Wales and England for more than ten years. Clinical Psychology is at the heart of that advance.

According to the Division of Clinical Psychology (British Psychological Society, 2014), Clinical Psychologists,

‘provide face-to-face therapy for individuals, families and groups. They also supervise and teach other professionals to provide psychological treatments... They offer leadership in organisational development, audit, service redesign and development.’

Distinct features of their clinical practice include:

- Comprehensive psychological **assessment**, which is vital to inform appropriate treatment plans.
- **Formulation**, a core skill of every clinical psychologist to make sense of an individual’s often complex situation, using psychological theory, rather than focussing on diagnosis.
- **Intervention and treatment**, which wherever possible is evidence-based. This includes challenging longstanding practice for which the evidence base is no longer strong.

It is also important to understand and appreciate the value that Clinical Psychologists can add to the work of the wider team, and to allocate time for these activities accordingly. *They enable the psychological capability and capacity of the whole system to improve*, and thus offer potential for far wider reach and impact than is possible from the delivery of direct clinical work alone.

For example:

- **Consultation** to the team, providing a psychological perspective in complex case work (formulation), and helping to ensure that the service user’s care is psychologically informed & appropriate to their needs
- **Supervision** to the wider team, providing expertise and support to ensure the quality of psychological interventions offered by clinical colleagues, and the capacity of the team to process difficult experiences and dilemmas they encounter in their daily work. This may also extend to facilitation of reflective practice across the team
- **Training** in low level psychological interventions to the wider team
- **Service development**, helping to design and test pathways of care that optimise wellness and ensure timely access to cost-effective treatments
- **Research and audit**, ensuring that our understanding of the field continues to progress, and providing vital data for team performance improvement

BPS Guidelines for Clinical Psychology Services (2011) are clear in advocating increasing integration into multidisciplinary teams, while ‘retaining the unique identity and contribution that psychologists can offer’.

4. What We Found

One of the most divergent areas of narrative throughout the review was about integrated team working. It was raised in almost every discussion. Perspectives as to the nature, extent and impact of integrated working between psychological therapies and the wider multidisciplinary team, both as a function and as a group of professionals, were diverse, sometimes even within the same team.

Descriptions ranged from 'integrated', 'involved', 'co-located' to 'fragmented', 'isolated', 'separate', 'not transparent', 'protective'. Where there was positivity, people spoke of professional respect, understanding of each other's roles, and shared ways of working. Where there was criticism, this was characterised as being the fault of those working within psychological therapies teams, rather than a consequence of the design, operation, capacity or culture of the system as a whole. Unsurprisingly, then, the subject often provoked emotive responses and appeared to be a barrier to constructive dialogue between different parts of the system. We observed effective interdisciplinary relationships in places, and in others, varying degrees of conflict, frustration and even hopelessness. It is our view that the evidence from the literature outlined above helps to make sense of what is happening and offers a direction about effective next steps.

The **organisational** context for the delivery of psychological therapies presents several challenges to interdisciplinary working, which are present to varying degrees across the specialties we looked at:

- It is not clear how psychological therapies feature in the organisation's vision for its services, despite positive work underway to implement the *Together for Mental Health* strategy through pathway redesign. There doesn't appear to be a common understanding of their definition, scope, potential, value or fit, beyond some very broad statements about a psychologically-oriented offer to service users. **Without a centralising concept for the contribution of psychological therapies to the wider vision, it is difficult for the system to know what it is trying to bring to life through its design and operation.** Smaller specialties have been more successful in carrying on regardless, than has been possible for AMH and OPMH, where Mental Health Measure compliance appears to be the basis for resource allocation.
- Psychological therapies are structured to sit alongside, rather than within, the rest of the multidisciplinary management structure. In most cases, budgets, capacity, workforce, planning, evaluation and training are managed separately, at strategic and operational levels. The rationale for this is not clear, and it is also not clear to what extent different parties want to see this change. We noticed a sense that the profession of clinical psychology feels the need to be organised as a distinct group. Whether this need extends to unidisciplinary management of the function of

psychological therapies is a different question. There are examples of various different operational management approaches across the specialities, some of which are clearly integrated, while others blur accountability and leadership. There is certainly a consistent message about wanting to work in a more integrated way, just not a clarity as to what this means in practice.

- Clinical leadership roles in the MH/LD Division (as distinct from professional lead roles) are occupied exclusively by Consultant Psychiatrists. We did not explore the rationale for this, but in a multidisciplinary mental health context, it is inevitable that other professional groups may find this lack of professional diversity problematic, and see it as a significant factor in the preservation of a culture and narrative which is medically oriented. We note this was identified in the *Together for Mental Health* local strategy, and it was raised consistently with us by people from various professions.
- There is a very significant and unsustainable mismatch between resources and organisational expectations (which themselves are unclear), and an absence of constructive dialogue about what this means and what might be done. Strategic opportunities have not been exploited and developments are piecemeal. On many occasions, we witnessed a chronic feeling of disappointment, frustration, misunderstanding, defensiveness and lack of trust with the organisation, particularly in AMH. This appears to feed a state of learned helplessness. This is particularly demoralising for individuals who work hard on the ground to find workarounds and piece together fragile solutions within their sphere of influence and responsibility. There was a feeling articulated by many people we spoke to that the professions involved in psychological therapies had become the scapegoats for much more fundamental root causes of the problems that manifest daily in services, most notably waiting times.
- Where stepped care is relevant, there is no commissioned integrated pathway for psychological therapies across the tiers (except CAMHS), and so services at different tiers generally work separately, and therefore use resources separately. Information sharing, supervision, training, capacity management were all raised with us as being problematic across and between the tiers, particularly where different providers are involved.
- Psychological safety to speak up was patchy. There was a strong undercurrent from most of the frontline staff we met that the organisation's longstanding status in Special Measures, and the events surrounding it, had gradually eroded its confidence to take positive risks towards innovation and improvement, or to trust its workforce to have the answers. It was perceived to be heavily centrally-driven, and incentivised around quantitative performance measures rather than quality. One

clinician described a flow of fear and threat amongst staff, when what is needed is compassion.

The lack of clarity at an organisational level has a knock-on impact. At **team** and **practice** levels, there is little within the system that enables what is espoused – a psychologically-minded offer – to become real. Staff do not appear to be supported or guided to cope within the resource constraints, and so are left with onerous decisions about how best to manage in a system that is not designed to perform effectively. It appears to be for local leads and managers to work out how they will operate together, and to do so without reliable data. Inevitably this gives rise to different arrangements with different impact and outcomes – some hugely creative and adaptable, others paralysed. Where it succeeds, it does so in spite of, not because of, the organisation. This gives rise to many different ways of working, which impact on access, quality and outcomes, and reinforces the postcode lottery which was mentioned frequently by staff and service users alike. It also nurtures the conditions for conflict (see p56). We saw many examples of teams working to their own set of rules about how psychological therapies should operate (e.g. referral, assessment, waiting list management), often determined without the full involvement of those who are affected by the rules. Those examples are not inherently wrong, and in some cases have delivered improvements, but they illustrate the lack of co-ordination across the system, and the measures that local leads feel they need to take, in the absence of any clearer organisational direction.

In terms of a common understanding of the role and value of clinical psychology to the wider service and team, we found considerable variation here too, at all levels of the organisation. The more the Clinical Psychologists and Psychological Therapists were integrated into daily team working, the more positive the relationships and appreciation of the role. Where they were working more remotely (for whatever reason), there was greater suspicion as to what their time is spent doing, and less inclination to see the benefit of their potential contribution beyond face-to-face direct clinical work. In this latter scenario, we witnessed fractured relationships, inadequate levels of trust, and missed opportunities to share expertise in the interests of service users and staff.

In summary, and while there were some notable exceptions, many of the conditions for effective team-based and interdisciplinary working highlighted in the evidence are absent in the services we reviewed, particularly at an organisational oversight level. The organisational ask is unclear, resources are inadequate, roles and responsibilities are blurred, and the system is not designed or incentivised to function as a coherent whole. The scope for conflict, therefore, is significant, and in many quarters, expressed. The literature would suggest that, in turn, outcomes for service users and staff are poorer.

While some specialities appear to be coping reasonably well in these circumstances, the consistent message from AMH in particular is that something needs to change fundamentally. It is our view that the organisation must play its part in laying the foundations for frontline improvement – supporting clinicians to achieve the very best – if it is serious in its commitment for high quality, psychologically-minded and accountable mental health and learning disabilities services.

What People With Lived Experience Say

In order to get a sense of the experiences of people who have used or tried to access psychological therapies services, particularly in adult services, we:

- asked Caniad to co-ordinate an exercise to gather comments, in which we asked:
 - what are your experiences of psychological therapies in North Wales?
 - what do you value about these therapies?
 - what would you like to see improved?
 - how can we work together to make this happen?
- invited the Service User Representative on BCUHB's Psychological Therapies Management Committee (who holds the same role on the all-Wales Committee) to participate in the area-based workshops. In turn, she facilitated some discussion with Bangor University's People's Panel to ask a similar set of questions;
- reviewed case studies provided by CAIS, which included direct quotes about a range of psychological therapies services provided by CAIS and Parabl;
- requested relevant information from BCUHB's Compliments and Concerns data
- invited Caniad representatives to participate in the area-based workshops
- reviewed an analysis of client and carer feedback about Clinical Psychology provision undertaken recently in Learning Disabilities services

While we were able to gather a range of experiences through this exercise, we recognise that this is just the start of a conversation which needs to become more inclusive and accessible across **all** specialties. This includes making reasonable adjustments to facilitate access, and ensuring Welsh language equity. We would urge BCUHB to strengthen the voice of the service user in response to this review. We make specific reference to this in our recommendations.

Therapy changed my life

- Therapy helped me to manage the triggers better by using coping strategies. It saved my life
- These therapies gave me resilience and coping skills and a safe place to practise
- Group therapies were good
- The service I received has been life saving. It has given me the confidence to do the right thing and move forward
- Someone who really listens and doesn't judge was a really big help
- It was a chance to tell my story and discuss problems confidentially
- I will always be indebted to you. You gave me back to my children and family
- You helped me to see that my future didn't have to be ruined by my past
- Through the professional, insightful, perceptive way you worked with me, you empowered me to keep moving forward
- My CPN is skilled in CBT approaches and I really value that
- I was treated with a lot of respect & [psychologist] understood me

I waited too long

- I was treated for 2 years by my psychologist. He became important in getting to where I am today. But I have had no contact since and would like a yearly update
- I waited over 2 years for an assessment and was then told that because my psychological distress and depression are related to complex physical health problems, it was outside the CMHT's remit. I am still battling with the same issues today
- I waited 2 years and my depression escalated to PTSD after my partner's death
- I wish I could have accessed help sooner
- I have been on the waiting list for psychological therapies for 4.5 years
- It's important to provide information about therapy before it starts
- I didn't get any information while I waited
- I have been waiting for 9 months for an urgent referral

The response I got wasn't consistent

- I wish I had not experienced stigma from my GP
- GPs don't seem to know what is available
- My referral went missing for nearly a year
- My therapist didn't understand my difficulties
- I feel there needs to be provision for a more person-centred approach to therapy
- There is too much emphasis on CBT. It's not helpful for trauma
- I wasn't offered any choice of therapies
- I didn't have a chance to share my experiences of therapy. I wasn't asked if it helped me
- I wanted to have therapy in my first language (Welsh) but it wasn't available

Our Observations

What you read in this chapter is our interpretation, as reviewers, about what is happening. Others will have different interpretations. Themes will feel applicable to teams, areas, specialties and individuals to varying degrees. This is inevitable. Our intention is not to provide you with a 'diagnosis', but to offer you a series of observations based on the discussions we have had, and the evidence we have reviewed. While we have broken down the narrative into a series of themes, it is essential to see them as a systemic whole, as the interplay between these different factors provides the real story.

Psychological therapies' strategic development and provision appears to be most advanced and resilient in CAMHS, SMS and LD. Common themes that cut across these specialities include:

- Fully integrated team working, in which both the culture and the processes within teams are designed to facilitate multidisciplinary working around the service user.
- Clarity as to how best to make use of limited specialist psychological resource. Team skills around psychological approaches have been developed proactively over time, so graded work is made possible across the whole workforce. Skills are developed through training, consultation and supervision for the MDT from the Clinical Psychologists/ Psychological Therapists. One-to-one therapeutic work has been reduced to enable this, and overall the capacity of the service for psychologically-informed care has increased.
- Team processes and ways of working are shared – e.g. referral, assessment, intervention, supervision, training.
- Innovative approaches have developed out of necessity – e.g. as a result of lack of access to other options.
- Active research, audit and development activity, including with university partners.

However, there are challenges that remain and it is important that these are not overshadowed by the entrenched difficulties affecting other specialities. These include:

- The wider organisational themes described below. While these specialities may have been more successful in making progress in this context, it is nevertheless the case that they are part of the same organisation in which the value and fit of psychological therapies are unclear, the strategic workforce requirements are not planned, the electronic data systems are

unfit for purpose, and Measure compliance has become the centralising concept. The organisation's reliance on individual performance to offset the systemic weaknesses in provision leaves it exposed. The potential for these specialties to go further faster with the support of the organisation is substantial.

- The limited opportunities to share learning (e.g. integrated team working) and explore collaborations across specialties. This includes better joint working at service interfaces – e.g. co-occurring needs; pathway transitions; mental health care for people with a learning disability.
- Demand outstrips capacity, so the care system is not able to deliver the right care in the right place at the right time. These specialties have made strong progress in finding creative solutions to spread the impact of specialist resources more widely, but still, waiting times for assessment and treatment are considerable and, in some cases, growing.
- Whole system commissioning is not in place, so the efficiency of primary and secondary care capacity across the spectrum of need is compromised.

There is ample evidence of positive practice happening across other specialties – namely AMH, OPMH and Forensic and Rehabilitation Services. Third sector provision is fundamental to community connection and resilience. Frontline staff have delivered local improvements for service users, in very challenging circumstances, adopting and adapting learning from elsewhere.

There have also been successes in securing extra funding via specific national investment pots, thanks to the persistence of senior Clinical Psychologists who take every opportunity to make the case. However, these improvements lack strategic oversight and commitment over the longer term, so their impact is not scaled. They proceed without a clear and mutually-agreed overarching plan. They rely too often on individual effort, goodwill and determination to combat the lack of infrastructure and other constraints. This also risks disengagement of staff whose local initiative isn't seen to be matched with more senior commitment. The potential of the effort being made is not fully realised.

The voice of the service user is not proactively or routinely available to or heard within service delivery. There is consistent involvement through Caniad in initiative-based project work with strategic leads, and also in specific peer roles in SMS. Caniad facilitated a valuable exercise to contribute to this review. There is longstanding service user participation in the PTMC. We are not in a position to comment on the effectiveness of these arrangements. However, when looking at the day-to-day operational business of services, we didn't find embedded examples of people with lived experience working as part of the interdisciplinary team. We didn't find a consistent approach to gathering and understanding diverse patient experiences. Staff talked genuinely about the importance of high

quality care for service users, but didn't seem to perceive them as potential partners in service planning and delivery, or more broadly, to recognise the value of lived experience in the development of effective services. When we asked at the workshops if one of the recommendations from this review should relate to advancing co-production in services, just one person agreed. It is our view that this is a key area to build upon and bring into the core of frontline delivery and improvement.

Equality of access is compromised as a result of lack of strategic planning, commissioning and delivery. The map of service provision varies widely. An individual's access to specific therapies is determined by the skills set of the clinician s/he happens to see, which may or may not coincide with his/her needs. There is a reliance on CBT. Opportunities for planning across teams and areas (e.g. to create a critical mass of expertise in DBT) do not appear to have been taken. The same is true for other aspects of access, such as language or other communication needs. There is no standard operating approach across teams of the same nature (e.g. CMHTs). This is the postcode lottery writ large.

The value and contribution of psychological approaches to a coherent core offer are not defined, recognised, resourced or embedded within the Division's culture or vision, despite a commitment to an attachment-informed approach. There is some way to go before the commitment translates into a workable centralising concept for culture, service development and delivery, which is inclusive of diverse professions and perspectives, including those of the service user. Resources are inadequate to make a multidisciplinary psychological offer a reality, and those that are available are not aligned for this outcome. This 'say/do gap' impacts on staff morale and engagement, conflict potential, strategic and operational improvement opportunities, and ultimately, better quality care. Strong views were expressed through our area-based workshops that staff across professions feel detached from their leaders, and lack confidence that the best decisions for improved care will be made. Reference was made to the long term impact of 'Special Measures' status on the willingness of the organisation to take positive risks in order to innovate and move forward. Terms used to describe what is needed to bridge the gap included 'radical acceptance' (used in DBT) and 'truth and reconciliation'. Staff can't be expected to practise in psychologically-informed ways without experiencing the same ethos as employees.

The potential for clinical psychology expertise to contribute to service transformation across the entire organisation is under-utilised. Clinical Psychologists are amongst the most highly trained professionals within the NHS, bringing specific skills and understanding that have the potential to enrich service responses at a strategic level as well as a clinical one. The under-investment in this part of the multidisciplinary workforce means the organisation is missing

opportunities to leverage that expertise towards some of its most ‘wicked’ problems – such as responding to the most complex, high risk and costly needs within the patient population; building resilience across communities to reduce demand on specialist services; and supporting the workforce as a whole to cope with the emotional demands that their work places upon them. This potential is untapped not because it doesn’t exist, but because there is insufficient capacity, and some believe insufficient support, to make it happen. Building a bridge between a strategy for psychological therapies and the overarching strategic objectives of the organisation is fundamental to the stated ambition for psychologically-informed care for all.

The conditions for high quality interdisciplinary working are variable across the services. Some specialties are clear about their shared team goals, the interdependence of their roles, and have opportunity for reflection as a team. There are large parts of services where this is not the case, and it is here that conflict is most apparent. The narrative in Chapter Four draws out the themes in our findings on interdisciplinary working, while the evidence base presented there offers clarity as to a way forward.

The Division is a group of distinct geographical areas and specialties, with different cultures, values, history, ways of working, that has been assembled with organisational needs in mind. Its existence as a single entity is of limited relevance to each of its component parts, whose first loyalty is elsewhere. We met many values-driven individuals, but we did not hear people talk about *shared* values. There is an inherent tension between Divisional and place-based solutions, and one which some areas feel strongly has not been managed sensitively or fairly. There was a powerful pushback in some quarters to the notion of a standardised approach to ways of working, based upon the stepped care model. When we explored this, it became apparent that it was not an aversion to tackling the postcode lottery, reducing unwarranted variation or improving sustainability. Instead, it was a fear that a top-down solution would be imposed, that lacked the sophistication to respond to local circumstances and needs, and would favour some parties or areas over others.

Compliance with the performance metrics of Mental Health Measure (or related targets) is the organising principle for service delivery. The core offer hangs around this requirement. Disjointed system resources are not ‘right sized’ or joined up, so demand and capacity do not match. This results in waste, waits, and failure demand. This is most evident in AMH. The organisation’s primary operational focus is on the ability to meet ‘front door’ assessment targets. Accessing rapid assessment is an important quality indicator, and so this is not, in itself, a bad thing. However, the consistent account from frontline clinicians is that capacity for intervention is diverted towards assessment. There are several factors at play here:

- Capacity that is located ‘upstream’ of the single point of access is inadequate to respond to the demand placed upon it, so the volume and type of assessment is greater than the services can manage, without compromising intervention. While the data to back up this conclusion is not captured, it was the overwhelming anecdotal feedback from the wide range of people we spoke with.
- Capacity that is located ‘upstream’ of the specialist psychological therapies services is not psychologically oriented, and so early opportunities to support self management through low intensity interventions are lost. This leaves psychological needs unaddressed and exacerbated over prolonged periods of time, and risks raising expectations that when specialist treatment is eventually made available, it is some kind of magic answer.
- Capacity across the whole system is managed in silos. This results in the system generating its own demand (known as ‘failure demand’). The requirements for timely, effective and high quality stepped care, as specified in the Measure, are not met. Capacity is wasted through duplication, lack of shared information, decision making, care planning, co-ordination and strategic planning.
- Lack of timely access is likely to increase the extent of need (and therefore cost) as people become chronically unwell. This has knock-on consequences across other aspects of life, such as employment, housing, and relationships, which may necessitate the use of other public and community services.
- Staffing levels in psychological therapies are inadequate to respond to the needs in the system as it is currently designed. It is neither realistic nor desirable to simply do more of the same. Those specialties which have focussed on building psychological capability across the professions are better equipped to address this challenge (CAMHS, SMS and LD).
- The lack of direction from the organisation to its services as to how these resource constraints should be managed, coupled with a lack of confidence that the organisation understands the realities of frontline delivery or the specifics of psychological interventions, leaves many staff working unsupported in challenging circumstances, which push them to the edges of their values base. This has a knock-on effect upon staff engagement, and thus quality.
- The scrutiny of national targets for an organisation in Special Measures is particularly rigorous.

In short, the demand being placed upon services is a function of both population need **and** system design. The capacity to respond is inadequate, resulting in long waits for help. In turn, this creates more demand, as people become more unwell. It is a vicious cycle that causes system harm to individuals, staff and the organisation. The introduction of the new 26 week waiting time target for AMH

psychological therapies presents an additional challenge. It is our view that a sustainable solution to delivery will necessitate a significant redesign of the current system. Right sizing the system will require a two-pronged approach in some areas, particularly Wrexham AMH – one to tackle the legacy of excessive waiting times (non-recurrent), and another to design a pathway that can cope with today's work (recurrent). We cannot see a cost neutral solution to this problem, but nor should it be simply investing in more of the same.

Stepped care is reliant on a range of factors to work effectively. The existence of services that map loosely onto each of those steps is not sufficient, as is recognised in the Measure. It requires interaction between steps to match demand to capacity and skills, shared working methods, easy information flow, training and supervision across and between the tiers. It requires specialist staff to build capacity and capability across the system and workforce, rather than focus entirely on the delivery of one-to-one interventions. The design must not include perverse incentives that lead to barriers and bottlenecks at thresholds. Every clinician must be equipped with a toolkit of psychological skills, appropriate to their role. These elements are more apparent in CAMHS, SMS and LD, but in AMH, tiers of stepped care are fragmented and there are large gaps between tiers. There is no single integrated care pathway for psychological therapies. There is a sense of services being and feeling overwhelmed with demand, struggling in a system which is not designed to enable a psychological approach.

Commissioning of non-BCUHB services appears piecemeal and unco-ordinated. This applies to substantive arrangements within Tier 0/1, commissioning of out of area secure care (recognising this is part of an all-Wales arrangement), and ad-hoc individual commissioning for 'overspill' specialist therapy capacity. Contract monitoring arrangements of third sector provision seem transactional, and don't appear to have addressed a wide range of issues flagged by the providers over a long period (e.g. service thresholds; activity levels; mutual untapped opportunities). Additional services have been bolted onto or fitted into gaps in some areas over time (e.g. Active Monitoring), as a reaction to system under-performance rather than a strategic solution to it. This is not to say that individual services are not doing what has been asked of them; rather that the system is not designed, managed or incentivised to work as a whole.

Strategic workforce planning and development for psychological therapies across the Health Board, in service of an overall vision, are not happening.

Given the lack of clarity as to population need, existing workforce profile and organisational ask, this is not surprising. Some specialties are achieving some degree of strategic planning, but are limited in their scope of influence, and miss out on opportunities to be part of something bigger. Similarly so where funding bids have been made, they are broadly aligned to areas of need, but not

specifically aligned to a whole system strategy. Within the non-BCUHB provision, there doesn't appear to be any dialogue as to workforce needs, risks or potential.

Career pathways for Clinical Psychologists in most specialties are hampered by flat skill mixes and small numbers of posts. Band 7 entry level posts are not widely available. For other core professions, there isn't a clear route towards accreditation in psychological therapy. Progress to date appears to be driven mainly by individual interest and opportunity. Many of those who have trained expressed a lack of clarity as to their role, a lack of fit in the wider team, and in some cases, disillusionment as to how roles had evolved over the years, with more focus on assessment, and much less on therapeutic intervention.

For the multidisciplinary workforce as a whole, there are both practical and cultural obstacles to developing and practising psychological skills.

Training activity varies between and within specialities, and there are positive examples of initiatives, often in partnership with the university. There was a consistent view that there is insufficient time and funding to support the intention of a psychologically-skilled workforce. Training does not appear to be explicitly aligned to the vision of attachment-based care (in AMH).

Anecdotal evidence supports the view that professional supervision is embedded effectively across psychological therapies, e.g. it is job planned, so time is protected. However, there is no BCUHB supervision framework in place, and no supervision audit was available.

This was another of the most popular priorities for improvement through the area-based workshops.

The absence of an integrated electronic data management system hinders clinical information sharing, transparency around service use, demand and capacity management, intelligence-ed decision making, workforce planning, governance, assurance and improvement. This has a knock-on impact on the extent to which the culture of services is data-oriented. A core and dynamic management function in any service is to align resources in such a way that enables delivery of that service's agreed goals and priorities, to make adjustments as needed, and to be clear about residual risks. This requires reliable and easily accessible information about the impact of management resource decisions upon goals – objective data about service performance, including outcomes, triangulated with a narrative account. *This does not exist.* The consequences for all aspects of service delivery, quality and improvement cannot be overstated. More than that, it erodes trust and allows space for opinions and suppositions to become the prevailing narrative. In some parts of the Division's operation, this is plain to see.

Information systems for staffing and finance data exist, but data quality seems to be an issue. The consistent response to our requests for information was that it would first need to be 'cleaned up' or some explanatory narrative added before it could be released. This data cleansing is generally undertaken by the most senior Clinical Psychologist in the organisation. The absence of reliable real time data, accessible close to the locus of activity, is a significant hindrance to effective and transparent resource management.

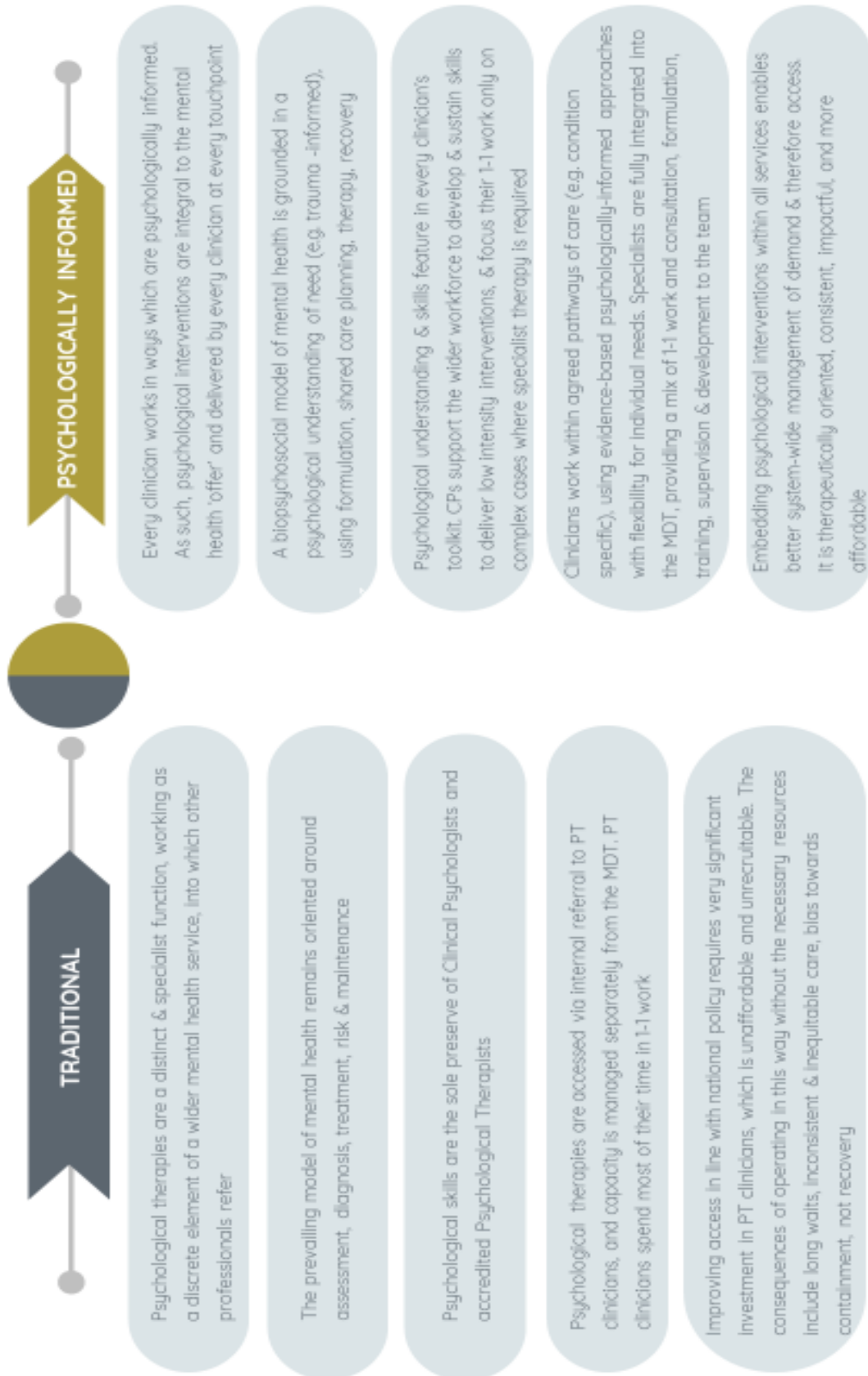
Standardised information systems for patient experience seem to be confined to concerns and compliments. When we requested information, it necessitated a manual exercise to compile the information and provide it on a spreadsheet.

Information systems within third sector provision are generally more robust, but are still activity rather than outcome oriented (as determined by their contracts).

We were looking for real time integrated information systems that equip managers with intelligence to make timely and smart decisions about service quality, safety and improvement, and which enable a culture of intelligence-led decision making. What we found was an accumulation of manual workarounds to capture isolated snippets of data for discrete reporting requirements, and a lack of engagement in some quarters to engage in providing service information. The risks associated with this situation are only too clear. A desire to prioritise action in this arena was the single most popular recommendation to come from the area-based workshops. We understand a comprehensive solution is delayed with an all-Wales solution (WCCIS). The question for BCUHB is what might it do in the meantime to move some way forward, in light of fundamental deficits in its service intelligence.

To coin a well-known improvement phrase, every system is perfectly designed to get the results it gets. If you wish to change the results, then you must be prepared to change the system. The following diagram attempts to summarise and simplify the basic options for improving access to psychological therapies. The hard work of individuals buried deep in the system will deliver marginal gains at best, while eroding their intrinsic motivation and discretionary effort. In order to achieve a step change – a psychologically-minded offer across the board – there are some courageous conversations that lie ahead.

OPTIONS TO IMPROVE ACCESS TO PSYCHOLOGICAL THERAPIES



Our Recommendations

What you read in this chapter are our thoughts, as reviewers, about what would help to move your improvement ambitions forward. It builds on the conversations we had throughout the process, the ideas you have, and our experience and expertise in this field. We have sought to strike a balance between highlighting the areas we see as essential to progress, with sufficient scope for you to shape the recommendations into clear actions that are tailored to your specific circumstances.

The recommendations do not attempt to address every detail of every service. This is not a finite list. Instead, they are focussed on the issues of greatest strategic significance to the design, delivery and continuous improvement of psychologically-informed care to the people of North Wales. They complement each specialty's 'Specific Key Questions' in Chapter 3.

1. Focus first on engaging staff

Staff engagement trumps all other measures for predicting the quality of organisational outcomes. Bring together a cross-specialty group of people, chosen for their passion and expertise in psychologically-informed care, who represent a diverse cross section of the multidisciplinary workforce. Give them dedicated time, a specific brief, the freedom to act and some independent facilitation. Sponsor the work at Board level. Plan from the outset to embed an appreciative style of collaboration, building upon existing work around strategy implementation. Make the primary goal to build trust. Consider if a reverse mentoring initiative between this group and the Divisional leadership team would be valuable.

2. Co-create a vision for psychologically-informed approaches

Come together as a diverse group of stakeholders to explore why this matters to you. Bring the conversation into the heart of the organisation's narrative. What do you mean by 'psychologically-informed care' across the board – from mental health and learning disabilities to cancer to long term conditions? How can it help you to achieve your BCUIB vision? What needs to change in your system and your culture to make this a reality? Clarify the role and accountability of the Psychological Therapies Management Committee and consider if it is constituted and functioning effectively to deliver against that role. Create safe space to explore the particular inter-professional challenges within the mental health field. Co-produce the vision with your partners as well as people who have recent experience, and set out how the voice of lived experience will be embedded in

service delivery. Consider if there are better ways to work together with the third sector, pooling respective strengths to grow community resilience.

Align it with a vision for the relationship that BCUHB wishes to have with its employees – a psychologically safe, values-driven employer of choice, which enables people to thrive.

3. Design and equip pathways of care that are fit for purpose by:

a. addressing the legacy waits in East Adult Mental Health

Design and resource a specific non-recurrent solution for the backlog, which addresses any outstanding cultural change as well as direct clinical capacity. Simultaneously ensure the service is designed to cope with today's work today, participating fully in the work around stepped care described below.

b. making stepped care a reality

Look across the whole system, both horizontally and vertically, to work towards the right care in the right place at the right time. This can't happen in specialist psychological therapies services alone. It requires better collaboration across team, area and organisational boundaries – a strategic approach. The current fragmented system design means there is insufficient capacity at Tier 1 to intervene early and pull demand away from specialist services. Be willing to redesign tiers or services, and to allocate resources differently, to ensure capacity and expertise is aligned for timely access. Make the links with other sources of feedback, such as the Joint Thematic Review of CMHTs and Delivery Unit reviews. Consider operational improvements such as standard operating procedures, step up and step down protocols, information sharing, joint capacity management, supervision and training across tiers, outcome measurement. This may need to look slightly different in different areas, but tackling *unwarranted* variation in access to and quality of care must be a priority to end the postcode lottery. This is a very big challenge for some specialties, so make effective use of pilot approaches to establish proof of concept through iterative change cycles.

c. tackling inequality of access

Service users experience wide variation in access that is unwarranted. They may be disadvantaged in receiving timely evidence-based interventions as a result of where they live, what co-existing needs they may have, how they communicate, whether they are marginalised. While much of this variation can be explained, much less can be justified. There is a known data deficit here, so the first task is to understand what can be achieved to improve your understanding of the specific issues around unequal access.

d. looking at out of county repatriation potential

Local people are leaving their homes and their roots in order to access specialist care out of county, as a result of gaps in local pathways. There is significant potential for psychologically-oriented solutions to make a transformative contribution to the repatriation of people with complex and long term needs. Clinical Psychologists have a unique skills set to offer to these challenges, but lack of capacity and opportunity are barriers to improvement.

4. Devise a strategic workforce plan and phase its implementation, with clear resource commitments at each stage.

Specialities which have made clear progress in embedding psychological approaches across their services have done so by ensuring that workforce design complements a well-informed service vision and strategy. They pull in the same direction. Capacity building requires specialist time and expertise to be allocated to multidisciplinary training, supervision, team consultation and service development. It also requires multidisciplinary role design to be centred around therapeutic outcomes. It is important that additional investment, which is inevitably needed, is not simply ploughed into doing more of the same, but that it considers the development needs of the multidisciplinary workforce as a whole.

Specific actions might include:

- Gaining a clearer understanding of population need alongside existing workforce and capacity design. What do we need and where?
- Developing a clear career pathway for clinicians who specialise in psychological therapies. This might include development of a more diverse skill mix, cross-speciality opportunities for continued professional development, a leadership development offer for Clinical Psychologists, and opportunities for advanced practice (e.g. specialisation; approved clinician role). This should include practitioners who work within primary care (Tier 1).
- Designing a skills escalator, which describes the psychological toolkit that every clinician will have, from support worker through to consultant psychologist and psychiatrist.
- Reviewing the role design of care co-ordinators, to ensure every clinician has the opportunity to practise in therapeutically oriented ways.
- Designing a workforce training plan that serves the needs of the vision and strategy.
- Ensuring that the conditions for psychologically-informed practice are designed into the workforce and what is asked of it. This includes management practices and behaviours that nurture psychological safety and trust.

5. Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.

Specialties that are able to demonstrate clear evidence of psychologically-informed care have created the conditions for effective interdisciplinary working to happen. Where this is not the case, it is vital for it to happen. This is unlikely to be a 'one size fits all' solution, as different teams have different starting points, but a common approach to define what you do to nurture team-based working could make a valuable contribution.

6. Pay attention to the enablers of change:

a. take urgent action to tackle the gaping intelligence deficits in services

Recognise the scale of risk that is associated with the current paucity of intelligence-driven decision-making, both in terms of quality, safety and effectiveness, as well as less tangible aspects such as transparency and trust. What can you do while you wait for an all-Wales electronic solution?

b. strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee

The fragmentation apparent in existing arrangements is a significant barrier to progress. The need for more effective multidisciplinary join-up is essential for both quality and culture. This should include clarity as to the leadership of the psychological therapies agenda in the organisation, as well as optimal operational management arrangements to nurture interdisciplinary working.

c. make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid 'big bangs' and initiative overload

Organisations that have a consistent approach to continuous quality improvement are able to accelerate progress, by building capacity and capability for improvement into daily work. The change agenda facing NHS services across the UK calls for a co-ordinated and tactical approach that focusses effort where it is most needed, in ways which appeal to the intrinsic motivation of staff to improve care. We strongly urge you to consider how your wide-ranging strategic implementation programme might embrace quality improvement methodology at its heart.

Roles and responsibilities

We strongly urge the Health Board to see the ambition for psychologically-informed care as an organisation-wide responsibility, sponsored and enabled by the Board. While the specialist expertise is held primarily within all-age mental health and learning disabilities services, the potential gains for all patients as well as employees is tremendous. It is not realistic to look to the specialist resource to meet this need. It is not possible to improve access to high quality psychological interventions by ringfencing improvement work in the specialist services. It needs everyone to play their part, and to create the conditions for success.

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Glossary of Terms

Therapies

ACT	Acceptance and commitment therapy
CAT	Cognitive analytic therapy
CBT	Cognitive behavioural therapy
CBTp	Cognitive behavioural therapy for psychosis
cCBT	Computerised cognitive behavioural therapy
DBT	Dialectical behavioural therapy
EMDR	Eye movement desensitisation and reprocessing
ERP	Exposure response prevention therapy
MBCT	Mindfulness-based cognitive therapy
MI	Motivational interviewing
IPT	Interpersonal therapy
TF-CBT	Trauma-focused cognitive behavioural therapy

Outcome Measurement Tools

C-GAS	Children's Global Assessment Scale
GBOs	Goal Based Outcomes
ESQ	Experience of Service Questionnaire
MFQ	Mood and Feelings Questionnaire
PHQ9	Patient Health Questionnaire (depression)
CORE10	Clinical Outcomes in Routine Evaluation (ten items)
GAD7	Generalised Anxiety Disorder Assessment
BSL23	Borderline Symptom List 23
BAI/BDI II	Beck Anxiety Inventory/Beck Depression Inventory II
HADS	Hospital Anxiety and Depression Scale
GDS	Geriatric Depression Scale
AUDIT	Alcohol Use Disorders Identification Test
PTOS	Psychological Therapies Outcome Scale
HCR-20 (risk tool)	Historical, Clinical, Risk Management-20

Reviewers' Biographies

Anna Lewis (Lead Consultant) helps Board leaders, senior managers and frontline teams to discover new ways of tackling complex organisational problems in sustainable, inclusive and human ways, primarily in the healthcare and third sectors. She draws on a wide range of expertise, from executive coaching, team-based working and asset-based approaches to quality improvement methodologies. She works regularly with the National Collaborating Centre for Mental Health (RCPsych). With 20 years' experience delivering and redesigning NHS mental health and social care services in senior leadership roles, she understands the realities of the work at both operational and strategic levels. She believes the people she works with have the answers they are looking for – her role is to call them forward.

In addition to her consultancy and coaching work, Anna is also a Trustee with Tempo Time Credits and an Independent Board Member with Hywel Dda UHB.

Dr Alison Beck has worked in the NHS for nearly 30 years, and is currently employed as Director of Psychology and Psychotherapy for South London and the Maudsley Hospital NHS Foundation Trust. She is a Consultant Clinical and Forensic Psychologist and a Systemic Psychotherapist. She has a particular interest in organisational development and compassionate leadership. She has completed the Kings Fund Top Manager Programme and the NHS Leadership Academy Nye Bevan Programme. She works regular with other agencies in health and social care. Within her NHS work, Al has been involved in numerous transformation programmes, as a manager, a consultant and an employee. She consistently finds strength and value in working closely with her colleagues to appreciate what works well and to form the fundamental relationships necessary for lasting success.

As a clinician, Al has specialised in the development of staff support services and in the treatment of people who have experienced trauma and their families. She seeks to build alliances and to work with people to harness their resilience and their capabilities to solve wicked healthcare problems. She contributes actively to London-based academic teaching programmes and she has published over 40 articles in peer reviewed journals.

Dr Amanda Clark has worked as a clinical psychologist as a practitioner, leader and transformation facilitator over the last 25 years, often working in partnership with service directors to support programmes of change. Amanda's most recent NHS post was heading up the People Development Team, applying her clinical skills in a more systemic context, contributing a psychologically-informed approach to developing staff and working practices across the organisation. Since leaving the NHS, Amanda has completed training in team coaching and worked with colleagues to develop an organisational development skills programme for health care staff (mostly clinicians) which was nominated for a national award. She has continued to work with teams across all levels of organisations, helping them to find effective and sustainable ways to improve their practice, drawing on her range of clinical, workplace mediation, coaching and organisational development skills.